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COCAINE BABIES

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

OCTOBER 16, 1987

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(100th Congress)

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COCAINE BABIES

FRIDAY, OCTOBER 16, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Fort Lauderdale, FL.

The committee met, pursuant to notice, at 10:30 a.m., Broward County Medical Center, Fort Lauderdale, FL, Hon. Charles Rangel (chairman) presiding.

Present: Representatives Charles B. Rangel; Benjamin A. Gilman, E. Clay Shaw, Jr.; and Tom Lewis.

Staff Present: Edward H. Jurith, staff director; Elliott A. Brown, minority staff director; George A. Gilbert, staff counsel; Rebecca Hedlund, professional staff; and Bob Weiner, press secretary.

The CHAIRMAN. The Select Committee on Narcotics Abuse and Control will come to order.

We are here at the invitation of Congressman Clay Shaw to get some idea of the impact of the cocaine epidemic that is sweeping our nation, the impact that it has on new-born children. This committee was just shocked and feel outraged at the drug producers and traffickers that have infiltrated our country, interrupted our law enforcement, caused dependency of so many of our young people and older people alike, and now have really caused so many infants, powerless infants, to be born with such debilitating diseases and abnormalities that it just seems to me that every politician, community leader, and spiritual leader should be prepared after walking through these wards to say this is enough.

We have recently passed a $3 billion bill through the efforts in no small part to Clay Shaw as we battle a budget deficit, but at the same time recognize that we had to establish priorities.

We know where these drugs are being grown, and we are still giving military and economic assistance to these countries, and we know what is necessary to educate our youth and we still do not have any national programs.

But we are here not to give speeches, we are here to get recommendations as to what we can do to help. We know ultimately, Dr. Udell, that we have to stop these substances from coming into the country, and ultimately we have to educate the American people not to use them, to understand the dangers.

These kids did not have anything to do with the world that we created. So, we have to do the best we can to make certain that we can make things a little even for them.

Before I recognize the rest of the members, I want to recognize Clay Shaw, one of the outstanding members of Congress, one of the most active members that we have on the Select Narcotics Commit-

tee, who made certain that we stopped what we were doing in the Nation's Capital to see what was happening around the nation, especially here in Fort Lauderdale, and as tragic and as hurting as the sight was, Clay, it is something we had to see if we intend to turn this around.

Clay Shaw.

[Statement of Chairman Rangel appears on p. 76.]

Mr. SHAW. Thank you, Mr. Chairman.

I want to thank you and our ranking member, Ben Gilman of New York, for coming down and also my colleague here in the State of Florida, Tom Lewis, to spend a few hours today looking at the tragedy that we have just witnessed.

A thousand hours of hearings in Washington, D.C., could not transmit the message that we have just witnessed. We have heard, all of us, that drug abuse is referred to as a victimless crime. We have just seen the ultimate victim of this crime, the unborn, whose lives are destroyed before they even leave their mother's womb, many of these, if not all of these, youngsters are destroyed by the absolute reckless ignorance of their mother in the use of drugs.

Dr. Udell, who has been a leader in the forefront of this whole matter, has advised us that the largest part of the damage that is done is in the first month or so of pregnancy, during the period of time when the mother does not even know she is pregnant.

I cannot believe that any woman in the world would be ghoulish enough to make this happen to their child if they have any idea what they were doing by their reckless conduct.

Charlie, you are absolutely right in talking about the problems and what we have got to do as far as the drug-producing countries. We have seen it in Mexico. We have had hearings around the border, border states, and then down into Mexico. We know what is going on in Colombia and where we have made some gains, but we also know that there are some other countries who just, frankly, do not give a damn about our problem.

We do care, and we have got a tremendous task before us, and we are learning everyday how bad the situation is getting and how absolutely tragic this situation is, and when you look at these tiny, tiny babies, it is enough to make you cry, but it is enough to make you so damned mad that we are going to have to get tough with this, we are going to have to do more, we are going to have to do more both in law enforcement, we are going to have to do a lot more through the State Department in cutting off aid, even as it affects trade with these countries, unless we get some type of cooperation.

But we also, as this committee has begun to do, we also have to focus on the educational aspect, and I think this is the biggest message that is going to come out of this hearing, and it is going to be up to a great part not only us, the lawmakers, as the funders, the keepers of the pocketbook in putting together educational programs, but it is also going to be the responsibility of the media to get that message out, to show the pictures of these premature youngsters, to quote the doctors as to their prognosis, what their future is or is not going to be, and to show how this is absolutely destroying lives of the unborn.

Again, Charlie, I want to thank you. You have been absolutely tremendous, you and Mr. Gilman, in working with this committee and bringing about the good results.

This has been a hard-working committee. For the benefit of people here, Charlie Rangel and Ben Gilman flew down this morning for this hearing and they are going back up to Washington this afternoon. It is all business. I think it is a most important hearing, and I think, Chairman Rangel, that possibly this could be one of the most, if not the most, important hearing that our committee will have all year.

I am very much in your debt for bringing this committee down and continuing to show the leadership that you have given, both you gentlemen have given, to this committee, and it is hard-working in nature.

I thank you, Mr. Chairman.

[Statement of Representative Shaw appears on p. 81.]

The CHAIRMAN. Thank you, Clay.

Ben Gilman is the senior Republican, but, more importantly, he is a friend and the vice-chair of this committee, and whether the meeting is held in Bogota, in New York or California or here in Fort Lauderdale, wherever the fight is, he will be there.

I am glad you were able to arrange your schedule to join with us here, Ben.

Mr. GILMAN. Thank you, Mr. Chairman, and I want to join with you in thanking our good member, Mr. Shaw, for focusing attention on this very serious problem that we saw in very graphic detail just a few minutes ago, the tour arranged by Dr. Udell.

I am pleased to be here with Tom Lewis, the other member on our committee, from the State of Florida.

This visit helps us better understand the needs for the education side of the problem, and we are here to seek recommendations from the health community, and I hope we come away with some worthwhile recommendations that our committee can take back to Washington to implement.

Drug abuse and drug trafficking is one of the major problems, if not the most important problem, confronting our nation today. It is so serious that President Reagan last year declared it to be a national security threat. It has caused the death of thousands of young people and adults throughout our nation. It is a worldwide problem. It is not unique to our own nation.

Today, it is estimated that the drug problem exceeds $140 billion, $140 billion of illicit trafficking in our nation. Not to mention the drug-related health costs and criminal costs that are estimated to be over $200 billion together. One corporation alone, General Motors, issued a report over a year ago saying just in their corporation alone, the drug-related health costs totalled $600 million.

Here today, as we visit the hospital and see the appalling picture of what can happen to premature babies who may not be able to survive because of drug usage of cocaine, that constricts the blood supply and oxygen supply to those youngsters, and then to think not only of the humanitarian concern, whether they can survive, but all of the health-related costs that go into making certain that that child has a normal future. The educational costs, the develop-

mental costs, are estimated to exceed $100,000 for just one youngster.

Sometimes, when we talk about the dollars we spend, we forget the overall impact, the financial costs to our entire community and our entire nation by not properly addressing preventive needs.

I can hope that this hearing will underscore the need for better education, education to prevent the kind of drug abuse that causes the problems we saw today.

Last year, Congress adopted an anti-drug abuse act, The Omnibus Anti-Drug Abuse Act of 1986, where, for the first time, with the help of both sides of the aisle, and virtually unanimous support, we appropriated $3 billion over a three-year period to attack the drug problem in both supply and demand, to try to reduce it at its source, through eradication, to try to beef up enforcement once it reached our shores, and then to provide the kind of help that is needed on the demand side, to do something about education, to do something about treatment and rehabilitation, and we hope that this hearing today with our experts who are here will help us find some better ways of more effectively attacking this problem.

Thank you, Mr. Chairman.

[Statement of Representative Gilman appears on p. 84.]

The CHAIRMAN. Thank you.

Tom Lewis' legislative responsibilities took him away from our committee for a couple of years, but he worked hard, fought hard, maintained his responsibility to his constituents and his other legislative committee assignments, and got back with us. We have missed him and it is good to have him back, and we thank him for coming down with us this morning and staying with us today.

Tom Lewis.

Mr. LEWIS. Thank you, Mr. Chairman, and I want to thank you for coming down to South Florida, you and Ben Gilman, this morning, and also to Clay Shaw, who has brought this particular issue to the forefront, with the Select Committee leading the fight in this country against the use of narcotics.

This cocaine epidemic that we see and that continues to increase certainly is appalling. Incidentally, Mr. Chairman, when I was in the state legislature, I never dreamed that I would be visiting a neo-natal clinic that I helped found just a few short years ago and find the degradation that we see in there with these young infants. It is just unbelievable! I think that the cocaine use amongst young women certainly is increasing and being brought to the forefront when you see this.

I do hope that we can in some way use this as an educational situation. I would like to see young men and young women come through these clinics, maybe this hospital can arrange tours, and other hospitals with neo-natal clinics can do the same to show just exactly what can happen. They can look at it and see that could be their baby laying there. It is costing $28,000 to $100,000 to take care of these babies. Their average time in here is four to six weeks, sometimes longer, sometimes maybe a little bit less. They not only have one disease, they may have a number of diseases, cocaine as well as venereal diseases.

It is certainly showing where we are going and the tremendous pitfalls that the use of drugs in this country continues to plague us

from our political arena, our law enforcement arena, and out into the family areas. We have got to do something about it and the only way we can do it is continue to hold these type of hearings. Through the leadership of the Chairman of this committee and people like Clay Shaw bringing the committee down here to see the actual facts, we can then present them to the Congress. Mr. Chairman, I hope we get the answers, some of the answers we are looking for.

Thank you for allowing me to be with you this morning.

[Statement of Representative Lewis appears on p. 83.]

The CHAIRMAN. Thank you, Congressman Lewis.

To this panel, let me thank you for the support and patience that you have given to Clay Shaw as he waited for us to rearrange our schedules so that we could come down here. We wish we had been here earlier, and I am convinced, as all of you went through your studies and wanting to help out human kind, that you never expected that you would be having to face the challenge which you face on a daily basis. Now we are here to try to get some of your recommendations.

Children are now being born addicted to alcohol, marijuana, cocaine, heroin, venereal diseases, AIDS, and then abandoned by their mothers. It just shows how devastating and how ravaging and how dangerous allowing these poisons to come into the United States can be.

We hope that through this forum, other people will see what you are going through every day, and perhaps can join you in trying to bring some answers to this insanity that, in my opinion, is a greater threat to our national security than communism because it is taking our children away from us and having them come into this world without parents by their side, with permanent physical and brain damage, but you are the front line troops and, Dr. Udell, you really have brought this tragic problem to the attention of medical people throughout the country, and we are anxious to hear your testimony, Dr. Wilson's testimony.

We know that you have been on a rough shift here in working around the clock, and we thank you for being patient with us, and also Ms. March, who is doing the best that you can to try to bring some family life to this tragic situation.

So, if there is no objection from the panel, what we will do is hear the testimony of all of you before we inquire.

Dr. Udell.

TESTIMONY OF BRIAN D. UDELL, M.D., DIRECTOR, NEWBORN INTENSIVE CARE UNIT, BROWARD GENERAL MEDICAL CENTER

Dr. UDELL. Thank you.

Ladies and gentlemen, my name is Brian Udell. I am the Director of the Newborn Intensive Care Unit, and a member of South Florida Neonatology, which is a group of newborn specialists who care for sick infants here at Broward General Medical Center in Fort Lauderdale.

I must say that you all have great staff people. Somehow, they really set me to thinking exactly what it is that I wish to present here today, and in my written testimony you have before you the

facts regarding the devastations that drug abuse and particularly the crack cocaine can wreak upon human fetuses.

The facts are that over two and a half years ago, I was hardly noticing any babies with cocaine in their system or cocaine in the families. When I started looking for it, I was finding one in twenty. By the end of last year, I was finding five percent incidence and now I am finding a twenty percent incidence. So, it went from one in twenty to a twenty percent incidence, one in five.

This year, we have a six percent increase in cocaine over last year. So, I have been spending a lot of my time going around the state and that is where I do a lot of my talks, and I try to educate people about the problems of cocaine, but the fifty or a hundred people that I talk to at any one time is just not enough to get enough people to know this problem, especially when you look at the fact that we had an increase this year in our cocaine abuse over last year.

But the vivid picture of tiny, silently-suffering infants which some of you witnessed this morning is worth more than a thousand words of scientific jargon. When your staff interviewed me the other day, I realized the need to describe the essence of over two years of frustration with my patients, their drug-addicted families and lifestyles, and the system which is not able to help these people.

What makes five or six infants in an intensive care unit here in South Florida so important that this respected body should assemble? Something is happening here. I want to tell you my observations that a virulent epidemic has germinated, that doctors and nurses need your help to discover and distribute the medicine.

From the only occasional observation that one of our families has a drug-related problem, it has become a daily occurrence. From only the occasional observation that a cocaine infant has suffered a cerebral hemorrhage and will suffer neurologic complications, it has become a weekly discussion.

From the only occasional observations that a cocaine-addicted mother did not seek pre-natal care nor does she visit or nurture her sick infant, this has become the rule. And on and on.

But I must mention a new occasional observation which has become all too common. It is the grim association between the sexually-transmitted diseases and AIDS is one of them and cocaine addiction.

These unfortunate infants really start out life behind the eight ball. The costs of this problem are staggering. Not only in the human sense of great pain and suffering, but also in the more mundane world of dollars and cents.

First, there is the increased cost from the small and premature babies with which the crack cocaine is associated. $100,000 is not an unreal figure for care in a newborn intensive care unit.

So, when we talk about only five or six infants, in a census that is low, that could possibly represent over a half a million dollars in medical costs alone. Multiply that many times, when there is nearly a twenty percent incidence in a unit of 800 yearly admissions. Then, add the costs the infant will incur if there is cerebral palsy, mental retardation, blindness or deafness, which would then require specialized care and schooling.

So, what can we do about all this? Well, we have to do something because the infants are here. There are three areas that I feel need to be addressed.

First, the infants must be protected. Once these children are discharged from our newborn intensive care unit, they are at an incredibly high-risk for abuse and neglect.

As I was saying earlier during the rounds upstairs, we found out in the seventies that infants who come out of a newborn intensive care unit are actually at increased risk for abuse and neglect just because they came out of an intensive care unit. It has something to do with the bonding or something that the infants are weak and they become scape goats in the family, but there is a problem for an abuse and neglect situation just coming out of a newborn intensive care unit.

You can multiply that many times when a mother is unable to control herself or a father, we should make this—understand this is cocaine-addicted families. They are unable to have any self-control and when an infant who has a shrill cry and is hard to soothe, starts to cry, we have had many incidences of child abuse under those situations.

We must have resources that include close observation so that more damage does not occur to the infants, and so that these infants can get some chance at a normal environment and development, and I often say, and it is in my written testimony, over the years, I have come to change when people ask me how many of these infants should be taken out of the home, what percentage, if they are doing cocaine in the home, the kid has got to get out of the home.

Nobody who is doing cocaine is normal. These people are criminals.

Second, the families must be offered real counseling. This takes resources, such as in-patient and out-patient centers, and people who can staff them. I understand that ex-addicts are sometimes the best counselors, and perhaps we could make some use of those people.

I found, for instance, if I—your staff asked me, what do the people say when they see people who are—what do the dealers say when they see people who are buying cocaine. Well, the dealers do not care, but one mother told me very poignantly that when she saw a pregnant woman buying cocaine from a dealer, it made her sick. She was sick. She was on cocaine herself, and she was going to buy cocaine, too, but it made her sick to see another pregnant mother buy cocaine from a dealer.

But probably the lowest cost and the best results come from public education and a public health system where pre-natal clinics are humane, dignified, and available. Prevention is the cure here as in so many other diseases, and a thorough pre-natal experience and effective dissemination of the pertinent information is what it will take to really begin to tackle such enormous problems.

I thank you all for your valuable time and attention.

[Statement of Dr. Udell appears on p. 87.]

The CHAIRMAN. Thank you, Doctor, for your very informative testimony.

Dr. Wilson, we thank you for your patience. We know you put in some long hours.

TESTIMONY OF MILES E. WILSON, M.D., MEDICAL DIRECTOR, SUNLIFE OB-GYN SERVICES, INC., BROWARD GENERAL MEDICAL CENTER

Dr. WILSON. Thank you, Mr. Chairman.

To the members of the committee, it is a great pleasure that I am given the opportunity to address this group and also to share some of the daily problems that I as an obstetrician experience with individuals who are addicted to cocaine and other abusive substances.

I think I need to tell you something about the group that I work with so you know the perspective from which I speak.

Sunlife Obstetric Services is a private corporation, formed in 1983, which services, in addition to the North Hospital District and South Hospital District, several other communities in the State of Florida, and we are also located in other states, more northern and some western states as well.

Our physicians are all fully trained. And either board certified or board eligible by the American Board of Obstetrics and Gynecology. We have selected a unique type of practice that gives us a different perspective on obstetrics than probably any other physician group in the country.

At Broward General, we deliver between seventy and eighty percent of the patients that are delivered at this hospital, and we account for approximately forty percent of all deliveries in Broward county. While we primarily provide care for an economically-disadvantaged population, all races are represented in our treatment clientele.

Broward General, as you know, is a level three maternity care hospital, which simply means is that we have the capability of treating very ill pregnant patients. Hence, our practice approach is geared to facilitate the care of the high-risk patient.

What do we mean by high-risk? We mean that the outcome of these pregnancies has less than optimal prognosis. Specifically relating to cocaine, this drug belongs to a class of compounds known as sympatho-magnetics or stimulants, which, among other things, cause blood vessel constriction.

During the first twelve to twenty weeks of pregnancy, cocaine appears to additionally be a teratogen and is associated with multiple congenital anomalies involving multiple organ systems, including the extremities, the heart, the kidneys, virtually nothing is spared.

There are chromosomal aberrations that also are suspected of producing decreased total chromosome complement. Fetal loss during the first twenty weeks of pregnancy is expressed as spontaneous abortion. However, later stages of pregnancy produce fetal death in utero or severely-growth retarded infants with a significant risk of succumbing to SIDS or Sudden Infant Death Syndrome.

The lack of growth that the fetus suffers presumably is due to poor nutrition, severe anemia, and chronic oxygen deprivation caused by a decreased uterine blood flow.

One rather eloquent physiologic experiment was written a year or so ago, used the medical researcher's best friend, a pregnant sheep. These researchers demonstrated that a forty percent reduction in utero placenta blood flow lasting approximately seven or eight minutes following intravenous administration of cocaine could be proven, and the consequences of such a catastrophe could easily prove lethal to an already-compromised fetus.

Such clinical experiments obviously are not possible nor feasible in humans. However, women using cocaine do relate intense uterine contractions and rapid fetal movements soon after cocaine use.

The goal of modern obstetrics is to deliver a healthy infant while preserving and promoting the health of the mother. In the case of maternal cocaine addiction, the primary treatment modality, which is pre-natal care, is most frequently denied. Pregnant patients using cocaine constitute a no-win situation.

Even if pre-natal care is obtained, lack of compliance produces less than desired results. In short, cocaine-abusing mothers represent one of the most unsolvable management problems in obstetrics. Such patients frequently present to the labor and delivery suite with increased blood pressure, hypertension, and or vaginal bleeding. Bleeding is due to premature separation of the placenta, known as placental abruption.

The infant still in utero, if it is not already dead, often exhibits a fetal heart rate pattern diagnostic of fetal distress and impending death. The patient who has recently used cocaine is typically brought to the delivery suite by emergency medical technicians since no plan of transport has been considered. The patient has not recognized or taken responsibility for her pregnancy.

The patient is physically violent, verbally abusive, responding to medical inquiries with statements of paranoid accusations. Quite frequently, she has to be restrained to protect herself and staff from injury. Sedation and other pain medications are not feasible since we have no idea how these are going to interact with some unknown street drug.

Labor, fortunately, is generally short, owing in part to the intense uterine contractions. Delivery by caesarean section also is not infrequent since such patients frequently exhibit fetal distress.

Conversely, vaginal delivery presents significant peril to the patient, the physician, and the delivering infant due to its often uncontrolled and precipitous nature.

Perhaps the best way to dramatize the sense of futility felt when treating cocaine-addicted mothers is to briefly describe two such patients that delivered here within the past thirty days.

Patient A is a twenty-three year old without the benefit of prenatal care. This is her second pregnancy. The first ended in spontaneous abortion. She arrived via ambulance, struggling with attendants and screaming obscenities. The patient was anemic. Cultures and blood assessment revealed syphilis, gonorrhea, and past hepatitis. The AIDS screening was negative.

Within thirty minutes of her arrival, she delivered a growth-retarded female infant requiring additional oxygen to adequately

breathe. This infant only weighed three pounds one ounce. Although by other criteria, the patient was judged to be thirty-six weeks gestation (a term pregnancy is forty weeks).

The infant no longer requires oxygen support but remains in the neo-natal intensive care unit. You probably saw that infant this morning. And she did require treatment for congenital syphilis.

Patient B is a twenty-six year old separated unemployed Medicaid recipient who has had six children. She received pre-natal care at Broward General's high-risk clinic and is thirty-six-thirty-seven weeks gestation at the time of presentation.

She attended a drug rehabilitation program during this pregnancy. Hospital arrival was by privately-owned vehicle. The patient last delivered in August 1986. That infant weighed six pounds fourteen ounces with urine which tested positive for cocaine.

The pregnancy prior to this occurred in 1985. That infant weighed five pounds fourteen ounces, died two weeks after birth at home. Death was attributed to sudden infant death syndrome.

Patient B lives apart from her children who are now residing with their grandmother. This patient, despite drug counseling, smoked one pack of cigarettes daily, frequently consumed alcohol, and smoked crack cocaine daily during this pregnancy. Her urine tested positive for cocaine on admission and one month before delivery, she was treated for gonorrhea and syphilis. Screenings for hepatitis and AIDS were negative.

Four hours after her arrival, she delivered a four pound four ounce growth-retarded infant but with no significant debilities observed. Mother and infant were discharged with public health home evaluation plan and referrals made to Broward Alcohol and Rehabilitation Center.

The cycle just continues. From my point of view, successful pre-natal management in the presence of maternal cocaine addiction is an unobtainable goal. The solution to me appears to embody at least two arms, one prevention and two salvage.

Prevention, as you have already mentioned, involves cutting the flow, stopping the flow of drugs. And a much more difficult problem, improving those socio-economic conditions which allow cocaine use to flourish and make it appear acceptable.

Salvage involves much of what is being done in the neo-natology unit, increasing support to drug rehabilitation programs. There are any number of programs advertised daily which invite individuals so affected to become part of their treatment program, but for the masses of people that are affected, these programs are not accessible. They simply cost too much and other programs, such as the Neo-Natal Center is involved with, include infant treatment and intense home monitoring of those infants as they certainly are at great risk for abuse as well as sudden infant death.

Thank you.

The CHAIRMAN. Thank you for your very moving testimony, Dr. Wilson.

Ms. March.

TESTIMONY OF ESTHER D. MARCH, R.N., B.H.S., DISCHARGE PLANNER/PARENT EDUCATOR, NEWBORN INTENSIVE CARE UNIT, BROWARD GENERAL MEDICAL CENTER

Ms. MARCH. Thank you, Mr. Chairman.

I am very delighted to be here and to have some input into the crisis that is now affecting our families, but before I go into any more detailed information about my concerns, I would like to explain to you what my role is and my job function.

I work in the neonatal unit at Broward General Medical Center as a Discharge Planner/Patient Educator, I prepare parents to take their babies home from the neonatal unit. Many of these babies require medical care at home and many special skills are needed such as home monitoring, CPR, medication and etc.

I have a great deal of concern because with any premature birth or sick newborn, there are a series of psycho-social crises that the parents must face. Most of these parents adjust and cope with these crises by the time the baby is discharged, but, unfortunately, what concerns me the most is an unresolved psycho-social problem, that many of the cocaine-addicted parents are facing.

Babies are still being discharged to unfunctional families. The family or the parent is very unstable, have unstable housing, few resources and is functioning at such a low level that they cannot or choose not to seek public assistance.

These parents' physical conditions, lack of motivation, and lack of attachment to their infant makes it very difficult to teach many of them the special skills that are needed for their infant's chance of survival.

Cocaine addiction in the family member's life is the driving force and that driving force or need will be satisfied over and beyond the need of the infant. I am aware that a referral system was developed last year to address this problem, however, that system has not yet met the needs of the community as you have stated, the other community members, Dr. Udell and Dr. Wilson have pointed out, babies are still being discharged to family members who have gone untreated.

They are untreated either because they refuse to acknowledge their problem of the cocaine addiction or because of the lack of available resources, for example the lack of in-patient beds in the indigent population. I would like to share with you two case examples.

A case that happened two weeks ago, where a mother delivers a premature baby boy, the baby remains in the hospital for seven days. Because of the mother's drug history and positive cocaine testing, a home investigation was done at the request of a public health referral. The report revealed open drug activity that was going on between the mother and three men. Two days later, a second home investigation was performed, the second report revealed no open drug activity at that time.

The home investigation was deemed satisfactory and the infant was allowed to go home with the mother. The mother was made aware of this. She came to the hospital to pick the baby up unprepared, without clothing or supplies, with a very strange affect on her face and alcohol was noted on her breath.

As the system exists today, it left us with no resources but to discharge this baby home with only public health follow-up, and as of yesterday, the community agencies were still trying to locate the mother and the infant for follow-up care.

Another typical example is where a single mother gives birth to a very severely-premature male infant, who remains in the hospital for three months. The child was ventilated and required multiple medical procedures which required the mother's consent, because of the mother's lack of contact with the neonatal intensive care unit. Her unstable housing condition made it impossible for us to locate her in a timely manner for any on-going consultation or for an update of the infant's progress.

The mother did come to the hospital after a referral was filed of abandonment with the HRS system. The infant remained in the hospital for three months, and the mother only visited three times. When the baby was ready for discharge. The baby required home monitoring, home medications, and the mother needed to be trained in infant CPR.

After several appointments were made with the mother to teach her these special skills, the mother did not keep any of the appointments. Four days later, after the baby's scheduled discharge date, the mother showed up. Training was implemented, but the mother minimally obtained the knowledge that she needed to take the baby home.

Uneasy as I felt and other members of the health team on discharging this baby, we had no course other than to follow the system as it now exists. So, the baby was discharged home with its mother.

I feel that these two babies and all other babies in similar circumstances should be protected by the legal system until the parents receive treatment for their drug addiction. These infants are at very high risk for abuse and neglect as has been stated by the two doctors, because of the powerful addiction. The addiction is a powerful source in the mother's life.

I also feel that treatment should be court ordered when the mother refuses to acknowledge her problem and until treatment is completed. The infant should be placed into legal custody of a significant other or an alternative situation. The services, which provide protection for these infants, should have some reinforcement as a support because the care-giver at this time is held responsible for the infants well being but has little legal application in directing care until the resources for this infant she is caring for because of the mother's dysfunction.

In many cases, significant others also complain that nothing can be done. I hope today that this can be resolved or some input can be gathered to help the significant others in their care of these infants.

The drug referral system has identified many high-risk drug cases, but there is a tremendous need for legislation, resources to help these patients with their drug addiction and to place the infant in a safe environment during the patient's treatment process.

Within the present legal system, only those drug-addicted infants who are abandoned are referred to protective services in a hospital

setting. I believe and I am sure the members of the committee believe also that the future of our country does not depend on us, but it also depends on the generation that is upcoming and that generation is our children.

Thank you for having the patience and time to listen to my statement.

[Statement of Ms. March appears on p. 106.]

The CHAIRMAN. Let me say this. We are on the brink of listening to what amounts to, in my opinion, criminal behavior, and we also are involved in some decisions that sound spiritual in nature because we are dealing with a moral problem here, and it seems to me, Clay, that staff ought to prepare summaries of the testimony that we have heard today and send a letter to the Governor to see what recommendations he would have because if I understand the testimony correctly, and any one of the three of you can interrupt, that we find that this has shattered the myth of motherhood as we know it.

They are just some human animals that have abused their bodies with cocaine, drugs, prostitution, that are able to conceive, that are not exposed to any type of education and many of them do not want it, that give birth to children, they abandon the children, leave them here, many of them born prematurely, diseased, addicted, physically and mentally impaired.

You take all of the training that you had to try to have as many as you can survive, and in many cases, where you are successful, you throw them right back in the cesspools that their parents found themselves.

I tell you that somewhere along the line, we are not being fair to these children, and I know the church should want to get involved before politicians start making decisions as to the billions of dollars that will be spent for having someone to survive that is going to become socially dependent and not make any contribution to human kind, and at the same time, see this epidemic sweeping the country.

We are a whole nation, as you said, Ms. March, and a large segment of the next generation can become just non-productive, if they are lucky enough to survive, and I wonder now in listening to this testimony whether the lucky ones die.

I think that our hearings are going to force us to dramatize not only what is happening in Broward County, Clay, but we have the same thing in New York with babies born with AIDS, hepatitis, no parents to be found, and the worst thing, Dr. Wilson, in most communities, and especially in the black communities, we have always had what we call the expanded family. It really did not make any difference if your mother was no count, there was an aunt, there was a grandmother, there was a friend, that would open up their hearts and their homes, and now, because of the fear of AIDS, we do not even have that. We do not even have foster care and the kids are just left in the hospitals for janitors and nurses and doctors to stop to pick them up.

So, Congressman Shaw, as we spend a large segment of our defense budget to stop the communists in Central America, I hope when we get back to Washington, we can persuade some of our colleagues that we have a real deep threat to the legacy that we all

hope that we will be leaving for the next generation, and as difficult as my job is, I can only thank God I do not have your job. To have to see this day in and day out with no answers, and if there was an international court of criminal justice, I would like to see the defendants to be the drug producers and the drug traffickers, and I do not think there is any sentence I could think of that would be too severe as to what they are doing to human kind.

Mr. Shaw.

Mr. SHAW. Thank you, Mr. Chairman.

Dr. Wilson, you brought up an aspect of this that had not really—the full impact of it had not really occurred to me. I had not really given it a tremendous amount of thought.

We have gotten from Dr. Udell the problems that are found after birth. We have gotten the statistical data as to what is the percentage of these children in his neo-natal unit who are affected by drug abuse.

There is one statistic we do not have, and that is the statistic affecting miscarriage, abortion. What percentage of these children that are affected by cocaine never reach Dr. Udell because of a pregnancy that is terminated, either by miscarriage or abortion?

Do we have statistics that would show that?

Dr. WILSON. I wish we did. There are a few studies that try to give numbers, but those numbers are not easy to come by. One of the many reasons is the same reason that it is difficult to determine how many women actually abort spontaneously each year from whatever cause. Many of these are simply not brought to medical attention.

In the case of cocaine use, how do you link the two? It becomes very difficult. How do you test an individual for cocaine use? It is a particular interest of ours to try to determine the percentage of population that is delivering who actually has used cocaine within a few days, a few weeks.

When you try to do that, you run into many obstacles. We are all sensitive in this country to invasion of privacy, protection of privacy. It is difficult for anyone to stand up and say we are going to drug test everyone that walks across the door.

That is what we would like to do, but I do not think there is any hospital group that is doing that yet. No one has taken that bold a step, save maybe some segments and some aspects of the military, but in the public sector, that information is extremely difficult to verify.

A study would have to be meaningful. You would have to test everyone, and we would like to do that, and perhaps we will, and then we will have good numbers.

Some vague indications say that the abortion rates are maybe fourfold increase in cocaine-abusing mothers.

Mr. SHAW. When a pregnant woman comes in to an obstetrician's office, do they not take urine samples and run that down as far as some of the background on the pregnant woman, and if that is the case, is drug testing a part of that general urine testing?

Dr. WILSON. No, that is not a part of the routine. Here at Broward, we treat drug testing as any other indicated laboratory test. If a patient exhibits changes or specific aberrations in character or mannerisms that make us think that she has abused drugs

or if she openly admits she is using, then we test, but not on a routine across-the-board basis.

That is the kind of testing you have to do to get meaningful, meaningful data.

Mr. SHAW. Let me follow that up with another question. It is the same question, but I am coming at it from a different angle.

We have seen that the children up in the neo-natal unit, of course, are all premature, that is why they are in there——

Dr. WILSON. Right.

Mr. SHAW. And we have seen that a percentage of the population, I believe you told us twenty percent, generally, and that is an increasing statistic, test positive for drugs.

What causes the premature birth? Is it the effect that cocaine has on the mother's body or is it the fact that the young child is somewhat damaged in the body and seems to try to push those children out early?

Dr. WILSON. Well, it is felt that it is really multi-factorial really. Because of cocaine's tendency to cause vessel constriction, the infant is severely compromised. The vital unit that links the fetus or the infant to the mother, the placenta, is likewise damaged.

Once this organ is comprised in its ability to transport or to deliver oxygen and food nutrients, then the infant is severely growth-retarded. The fact also exists that cocaine is a stimulant. It causes intense contractions.

Uterine eligibility or uterine contractions do normally occur throughout pregnancy, but the administration of cocaine causes much more violent uterine contractions and the patient has a tendency then to abort or to prematurely deliver whatever products there are in the uterus.

Mr. SHAW. Well, then, it would be fair to conclude from what you have said that a great percentage of these pregnancies are terminated at home by miscarriage, and you never hear about that?

Dr. WILSON. That is true.

Mr. SHAW. And they will never be part of the statistics that we are working with.

Dr. WILSON. That is true.

Dr. UDELL. Another thing that I would like to point out that we learn in medical school, when a patient says they smoke one pack a day, you can usually think two. When a patient says they have one beer a day, you can usually think two.

If I am finding one out of five, then there must be much more that I am not finding.

Mr. SHAW. I share Charlie's, Charlie Rangel, our Chairman, frustration, and I think his comment about how difficult your job is. You see the mother, see her through to delivery, you try to save the life of the child, you see the child going home to a family that is unfit.

Thank God you are in there fighting, but all of you are losing.

Dr. WILSON. It is discouraging.

Mr. SHAW. We are all losing. I appreciate and commend you for your testimony, for the work that you are all doing. I am very proud of the fact that I could bring this distinguished panel down here to talk to people who know so much of the distress that this problem causes in my community as it does across the country.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, before I recognize Ben Gilman, Mr. Shaw, I think we were talking here, and I know there is a right to privacy even with these crippled infants, but maybe if, in a professional way, you can see that pictures are taken that we can present a case to the Governor in a very non-political but compassionate way, maybe get some of our spiritual leaders involved in taking a look at this human tragedy, that it will not just be politicians and legislators, but people who are concerned about this generation and the next, and it is not as though we think we can win the battle, but Ben Gilman was saying maybe if the people just saw these infants, they might take another look at their bodies and what they are doing with them.

Ben Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

I want to thank this panel for very poignantly pointing out the dangers that occur from a potential mother's drug abuse and what it can do to the infant and the infant's survival.

Apparently, you are all saying some things together. Number one, there is very little education and that we are doing very little about warning the prospective mothers of the dangers and then doing very little in follow-up after all of this occurs.

Let me ask you. Is there any besides the one unit that is here in Broward County that does anything by way of education or follow-up for the prospective mothers or for the mother after she gives birth?

Ms. March was mentioning to us in the hospital ward room that she does not even have the authority to go to the home, is that correct?

Ms. MARCH. That is correct. I am hired by the hospital, so I function as a hospital employee. I do not have the authority to go to the community to evaluate the homes.

However, there is the Public Health agencies which has the authority.

Mr. GILMAN. Do they go to the home?

Ms. MARCH. Yes, they go to the home. The referral system developed last year, was implemented for this purpose to investigate the physical condition of the parent or the significant other home to see if it is suitable for the infant that is going home.

However, that system does need a lot more work.

Mr. GILMAN. Have you brought these problems to the attention of your state and local government, of the need for counseling services, the need for follow-up care?

Dr. UDELL. Yes. We have spent a lot of time with our local agency, our local HRS, which has tried to address the problem with this new statute where the public health worker goes out to the house.

I think the scope of the problem, however, is so big that it is overwhelming. I think that, for instance, a public health worker is typically a person who gives shots, okay, who helps old people, make sure they get fed. A public health worker is not a CYF worker, who goes out and really examines whether or not that is an abusive situation that that child is going to go home to.

Mr. GILMAN. What is CYF?

Dr. UDELL. Children, Youth and Families.

Mr. GILMAN. What would the panel recommend to us as your national representatives that we could do to try to help you overcome some of these problems? What would you recommend? What would be your major recommendation that could help us get through this cloak, this curtain, that has been drawn between the mother and the health agencies?

Dr. UDELL. I have come over the years to believe that we need to treat the woman or the family that is doing cocaine as criminals. If they are taking care of a child and they are taking cocaine, they are criminals, and on a national level, they should be considered criminals and, therefore, they should not be allowed to take care of their child unless they are in a drug rehab program.

Mr. GILMAN. Well, you are really talking about some local criminal laws that would have to be devised. That is not—I do not believe that you are then getting into any national crime. It would have to be something that would be done on the state level.

Now, what I am asking is, what can we do to help you in your problems of counseling, for example, and education and preventive measures, your follow-up measures?

Dr. WILSON. There are so many individuals who are affected by drug use, so many people that are currently using drugs, that we have a huge population segment. We are raising a generation of individuals with the most unpredictable behavior that you could probably imagine and unless we look toward salvaging these individuals, we are just going to produce more of them and more of them.

Mr. GILMAN. What do we do——

Dr. WILSON. We have to break the cycle.

Mr. GILMAN. What are we doing by way of prevention, for example, here in Broward County? Is there any public education program? Is there any education for mothers that come into your obgyn clinic? Is there any follow-up for the parents?

Ms. MARCH. Yes. At this time, there is some education in the prenatal clinic, but it is very minimal, and also March of Dime has some educational literature.

Mr. GILMAN. Who funds those clinics, Ms. March?

Ms. MARCH. They are funded by the HRS system.

Mr. GILMAN. Is it a state agency?

Ms. MARCH. Yes it is.

Mr. GILMAN. Is there any public education program? Any media programs?

Ms. MARCH. As far as my knowledge at this time, there is not a great deal of it, other than what comes through March of Dimes and through other agencies.

Mr. GILMAN. But nothing by the way of any major public media?

Ms. MARCH. No.

Dr. UDELL. No, and since we started talking about this over two years ago, there is still not a commercial on television that says it is bad to do cocaine for your babies and, you know, if you will not say, if the doctor does not say something is bad and you want to believe it is okay, then you say, well, nobody says it is bad.

There are a lot of commercials on television about not doing cocaine for yourself, about the basketball star who died, and the foot-

ball star, and this is what your brain looks like on drugs, but there is nothing to say this is what your baby's brain looks like on drugs.

Mr. GILMAN. Dr. Udell, you have made some very strong statements and really underscored the need to do a lot more in this direction.

Have you made any recommendations to your state legislature with regard to these problems?

Dr. UDELL. Yes, I have been involved with making recommendations. The problem is the bite. The problem is the line that gets drawn where you are impinging on the privacy of the mother, okay. The line gets drawn when you want to remove the child from the home.

The question that gets asked time and time again is where are you going to put the child. If I want to get the child out of the home, you tell me where we are going to put the child. Well, I do not know. I do not know. The significant other, as Ms. March said, is a very important help to us. The aunt or the grandmother who is willing to take care of it, but that grandmother, who has had six kids already to take care of, does not care to take care of the seventh kid.

Mr. GILMAN. I would be pleased to yield to the Chairman.

The CHAIRMAN. Doctors, the rough question that my colleague is placing to you in terms of whether or not you have been able to define a legislative remedy, but it just seems to me that we should be able to get enough people together to say, one, that before birth, this child is abused and that the child is abused in its mother's womb, when the child is born, it is abused, that there has to be some type of laws that are on the books to say that we have a legal responsibility not to put this abused child in the same setting that caused its birth in the first place.

I mean, we have Associations for the Prevention of Cruelty to Animals. You know, you can go to jail for beating a cat. So, I would like to believe that if you find something that God made, it just seems to me that the Right To Life, that people should have some group that will describe what life is.

I mean, they cannot just be concerned with protecting life before birth. I mean, they have to come and say that this is not what they are talking about, and we know how limited you are, but when we ask what you are doing in terms of making recommendations, and this is especially so, I would guess, to Dr. Wilson and Ms. March, you know, if you get them before birth, you are stuck with them after birth, and then you have to get rid of them out of the hospital because of the cost that is involved, we need someone else around this table to decide how do we get ourselves in this in the first place.

They are not going to listen to your moral and humane grounds. It seems to me that if it is going to cost hundreds of thousands of dollars for the kid just to survive, not talking about just the dollars and cents, what happens after the kid survives that is mentally retarded, that is physically retarded? We are talking about millions of additional dollars besides the human tragedy.

So, we hope that after we leave town, that you do not let us leave the issue and that you will come together and think of things that you would want done, and I would ask Clay Shaw to get your ideas

together and present this to the Governor and perhaps to the leaders of the state legislature that we will be doing it, indicating that we are not just dropping this problem on their steps, we want to work with them.

I am sorry, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Your point is well taken, and there are funds available, you know, in the Federal Government to help with treatment and rehabilitation and counseling, and what we ought to do is explore what we can do, local, state and federal, working jointly together to counteract this problem.

What are you talking about, Dr. Udell, about finding a place to put a foster child? To take him out of the home setting is a serious problem. We were confronted with that in New York City recently. We addressed the AIDS babies that are left in the hospitals abandoned by the family. There are very few places for them to seek a shelter in that situation, and then it becomes a public charge and a very severe burden, not to mention the survivability of that child left just without any parental care.

I would like to ask you, though, before I wind up my questioning, and I am exceeding my time, would you please just quickly reiterate the drugs that are dangerous to a prospective mother in your opinion?

Dr. UDELL. Alcohol is always dangerous. It has been for years, and the only—briefly, the only recent article that came out about alcohol is an article which shows that it takes a little more, about a drink a week or more, to really cause problems with the fetal alcohol syndrome. So that the concerns in the sixties and seventies that any amount of alcohol at any time during the pregnancy is going to cause a malformed baby maybe a little over-stating the case.

It is not to say to do alcohol during pregnancy, but once during your pregnancy is not going to cause a malformed baby, but alcohol certainly during the pregnancy is going to lead to a baby with mental retardation and physical problems.

Marijuana. I often talk about, I do not mean to understate the problem of alcohol by saying just worry about the smoke. There are currently studies coming out questioning what the effects of marijuana are on the fetus, and I think that if any woman just worried about the methane gas, the carbon monoxide gas, the breathing problems, sudden infant death syndrome from the smoke itself, you should not smoke during the pregnancy, should not smoke anything.

The heroin is something that we have known about for years, but the problem that I brought out to you all in the nursery with our methadon baby upstairs is that it is a continued drug lifestyle. The people have to get off the drug. The continued drug lifestyle is such that I have never seen a methadon baby here who did not have some other drug in the urine because the women are doing the methadon to get off the heroin, but they have not stopped their drug lifestyle, and I would like all the methadone clinics to know that methadone is bad for babies, and the best thing that they can do is wean the children off the methadone.

L.S.D. was a problem in the seventies, and once people found out that it broke the chromosomes, there was not any L.S.D. the next day because everybody was afraid of their chromosomes breaking.

There is a new generation, I am told by the police in Fort Lauderdale, now because L.S.D. is easy to get and is cheap, they are starting to use L.S.D. again, and it is a real concern whether that drug is going to come back, and then the designer drugs in the seventies were another problem.

People would mix a whole lot of different drugs and see what euphoria you could get. I think the whole point is just you do not take drugs during your pregnancy, and I have oftentimes met women who would not take an aspirin because they were afraid of what the aspirin would do, but they would smoke.

Okay. I think that the important thing for people to know is everything they are taking, the infant is taking, and what that developing fetus is taking is not only having an effect on blood flow and everything like that, but you are talking about a developing mind, the most rapidly-developed part of the body in the newborn period is the central nervous system.

The head of a child is a third of the size of the body instead of a fifth like it is in us. So, the most rapidly-forming and developing part is the brain, and we do not know what all these drugs are doing to a developing brain.

Mr. GILMAN. Now, you told us that twenty percent of your infants are cocaine infants. How many are drug-related infants?

Dr. UDELL. Well, we run about—there is an underlying one in a thousand incidence of absolute fetal alcohol syndrome, and to tell you the truth, cocaine is the biggest one. It does not get added up more than that. Of the twenty percent, it is probably about another five percent with the other drugs.

Mr. GILMAN. So, about a quarter of all your children have drug-related problems?

Dr. UDELL. Yes.

Mr. GILMAN. And of those, what percentage have venereal problems?

Dr. UDELL. Of the ones that have drug-related problems, we are now getting greater than seventy percent with venereal problems. Of the nine children upstairs that had cocaine in their urine today, eight of them had a venereal problem, venereal disease.

Mr. GILMAN. Twenty-five percent of your children are drug-related.

Dr. UDELL. And seventy-five percent of those are venereal diseased.

Mr. GILMAN. Thank you, Doctor.

Did any of the other panelists have any other recommendations for the panel before we conclude?

Ms. MARCH. Yes. I have one, Mr. Gilman.

One statement that I talked about earlier in my testimony statements was the need for some type of assistance program for the significant others who are taking care of these babies, I do not want you to dismiss without realizing how important it is that we need to reimburse these people who have taken on this responsibility, and maybe with this assistance, or giving them some resources for taking care of these babies and giving them some legal custody

rights to the care given, that might help the burden of the grandmother or aunt who is caring for the baby.

Dr. UDELL. What Ms. March is saying, for instance, we will have a baby who comes in here who needs us, who has a surgical problem and needs surgery, the significant other, that is the grandmother, brought the child in and we cannot do surgery because we cannot find the mother and they cannot sign a piece of paper so we can do surgery.

Mr. GILMAN. Thank you. I thank the panelists, Mr. Chairman.

The CHAIRMAN. Congressman Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

I believe that you certainly hit it on the head with your statement to Mr. Gilman's Mr. Chairman. I think we have only hit the tip of the iceberg in this situation.

I would like to ask you, Dr. Udell, the baby we saw this morning that had methadone traces, do you know whether the mother had previous drug-addicted children?

Dr. UDELL. I am not sure. Do you know that?

Ms. MARCH. The methadone baby?

Dr. UDELL. Yeah. The methadone baby. I do not know.

Ms. MARCH. No, she did not.

Mr. LEWIS. Well, the reason I asked the question, I have a copy of the legislation that you probably were instrumental in helping to pass in the legislature this year, and they conveniently amended it to protect against just the thing we are trying to determine.

When I look at this legislation, it is almost worthless as far as I am concerned, to give you the help and provide the help that is needed, and I think certainly we should be talking to the Governor to correct this.

Now, I think the legislator that presented this was doing the best he could, but another legislator told me exactly what happened when they amended in here the protection for the mother, and we get back to the privacy situation, and that is too bad.

We feel that the states should handle this sort of thing and then we have to wind up passing federal legislation at the agony of the states because the states refuse to pass the specific legislation needed to correct the problem.

I do not know what we are going to do. I have real problems when we get into this right of privacy because I really believe in the right of privacy, but that child has some rights as well when it is in the womb, I would think, what we are doing is protecting the mother who is providing drug-addicted babies. I just do not think we can continue to do that.

Have you in your relationships with the Medical Society and the Public Health Center, other types of centers that are dealing with young people, provided them information as far as the dangers of use of cocaine in the child-bearing ages?

Dr. UDELL. This is all just beginning to come out now. There is a great deal of work that is being done. Jim Perry, who is the head of the Florida Medical Association, just understands the problem very well, and we are beginning to try to address that specifically in our Medical Societies.

Mr. LEWIS. Have you found any link between cocaine use and infant death syndrome?

Dr. UDELL. It has been reported in several places right now and, you know, one of the most graphic things we talk about sometimes are the two mothers that we know of that sold the apnea monitor for drugs. The babies go home on a monitor that are at high risk for Sudden Infant Death. They go home on a special monitor to see if the baby is breathing or not at night, and two mothers that we know of sold the monitor to get drugs.

I do not know exactly who buys monitors, but they apparently did not have them anymore and when they came into the clinic, they were gone, the monitors were gone.

Mr. LEWIS. I would like to ask the whole panel. You probably answered this in some ways, but I will ask you very directly. Do you think that drug addiction at birth should be grounds for child abuse?

Dr. WILSON. Yes, I personally do. I really do. I had never thought of drug abuse, people who are addicted, especially pregnant women, in criminal terms perhaps before because I always considered that a real illness, like mental illness or any other disease.

But one of the patients that I presented is a perfect example. This was a woman who not only was attending a high-risk clinic, but also had received drug intervention, drug counseling. So, she knew. It was not as though she did not know. It was not as though she had not done this in the past, had not had an infant who died or did not know the consequences of this. This is someone who just did not care and that is disturbing.

You are in a no-win situation. Even when you provide the information, they still do the same thing.

Dr. UDELL. We had a mother here in Florida a few months ago who was giving a two-week-old cocaine, and she was arrested, and nobody had a problem arresting her for giving a two-week-old cocaine, but the day before she delivers, she takes a dose of cocaine and, therefore, gives it to the baby, everybody is worried about her rights.

What I think that we have to come to grips with is that a pregnant mother is giving up some of her rights for the rights of the fetus. At some time in a pregnancy, she has to—we all have to come to grips with that change.

Ms. MARCH. And I also agree with both Dr. Wilson and Dr. Udell that it is a cycle, a habit, that is forming, and if she is using the substance while she is pregnant, with no concern after being given the information, it would not help her. I think she should be charged with abuse because she is not going to stop taking drugs once her child is born.

Mr. LEWIS. If I may continue further on this, do you feel Ms. March, that the child should not go back with the mother until the mother is under rehabilitation?

Do you think that there should be conclusive a decision made that the mother has been rehabilitated before the child is returned to her rather than just fund her rehabilitation program?

Ms. MARCH. Yes. That is one of my strong points. I do feel that some type of system should be implemented so that the mother is forced into rehabilitative services and is made to stay there and be rehabilitated by the time she gets out, so that she can care for her child. I do agree with that.

Mr. LEWIS. How about you, Dr. Wilson?

Dr. WILSON. Absolutely. Absolutely.

Dr. UDELL. I think perhaps if her rehabilitation could be tied in with absolute protection for the child, the child maybe could be returned to the home, okay, with, you know, under close observation from some agency, you know, to make sure that she is staying off the drugs while the child is at home.

I mean, again, the problem is logistics. Where do you put the children.

Mr. LEWIS. Do you not feel then you would be able to locate her as well as also be able to make sure that you can provide the follow-up necessary inspections for the child itself?

Dr. UDELL. Absolutely. That is one of our big problems, is finding these patients.

Ms. MARCH. Also, in our community, we do have some programs for rehabilitative-service, but the length of stay is very short and the amount of beds available to help these people, are limited, and, so, the population goes untreated.

Mr. LEWIS. I would like to ask all the panel, if we had held this hearing in any of the other nine cities or locations where we have neo-natal clinics, that we would be hearing the same kind of concerns that you are expressing to us today?

Dr. UDELL. There was an article, I was saying to some of the committee members this morning, an article, I saw an article in the recent Journal of Pediatrics from San Diego, there has been a recent article in Philadelphia. New York had a great article this year.

I think all the bigger cities are starting to come out with the—the research centers in the bigger cities are starting to come out with articles about their cocaine population, and you cannot do that until you have numbers.

Mr. LEWIS. Well, it is obvious we have a lot of work to do. We have got to the point now where the basic foundation of our society are allowing drugs to destroy it. We have got to do something about it and wake up. Again, I believe we need a commitment from the American people if we are going to whip this problem.

Mr. Chairman, I thank you for allowing me to query the witnesses.

Thank you very much.

Mr. SHAW. One further observation. That is that to follow-up on Congressman Lewis' questioning and comments with regard to how widespread the problem is.

Dr. Udell was one of the first, if not the first, really to get this message out, and I would like to recognize him for that, and express our appreciation for his leadership and the pioneer way of getting the message out that cocaine does come to the baby and whatever the mother takes, she is giving it to the baby.

I would like to ask one last question, if I can. Tom was talking about Section 415 of the Florida Statutes, which does define drug abuse as child abuse during pregnancy, but also that same statute has a prohibition against criminal prosecution.

I will read it. It provides that "no parent of such newborn infant shall be subject to criminal investigation solely on the basis of such infant's drug dependency." That language is disturbing, but obvi-

ously I can see the reason for it is because they were concerned about parents going underground, having the kids in back rooms and things of that nature to avoid this possibility.

I would like to ask the panel just very quickly. One, has the amendment to this statute in question, which has only been in place, I think, for a year or less than a year, have you seen, have you seen where it has helped and, also, do you see whether or not it has or do you have an opinion?

Dr. UDELL. It is definitely a beginning. The reason I got involved is as a pediatrician, I felt if you see an infant in the emergency room with multiple trauma, you are bound to report that as possible child abuse. You are protected and you are mandated to report that as child abuse.

When I started seeing infants with cocaine in the urine, I was reporting that as child abuse, and I was not getting any response, and now I can get a response from the state on that. That is the beginning of it, and I think that that is where we are right now. We have begun to address the problem with that statute.

The CHAIRMAN. Any further questions?

Mr. GILMAN. Yes, Mr. Chairman. Thank you.

Just one more question to the panel. Are you beginning to see any problem with youngsters afflicted with AIDS?

Dr. UDELL. As I said, the venereal diseases, one of the venereal diseases is AIDS, and we have seen several of the infants where cocaine was abused, we tested them for AIDS and found them to be positive, and those infants are incredibly difficult to place. Not only that, I have had the unfortunate occurrence of having to tell the mother that she had AIDS, too, because I tested the baby for it. Two mothers like that.

Mr. GILMAN. Is there any testing of the cocaine babies' mothers for AIDS? Do you do any of that?

Dr. WILSON. We do. We do. This is another one of those indicated tests. Whenever a significant suspicion has been aroused, then we go the full gamut. We test for hepatitis, AIDS, and all the venereal diseases.

Mr. GILMAN. Are you finding a high incidence of AIDS?

Dr. WILSON. No, not really. Not as far as cocaine-abusing mothers are concerned, no, we are not.

Mr. GILMAN. In heroin-abusing mothers?

Dr. WILSON. Well, heroin is a rather unusual drug to find these days. Cocaine seems to be so much easier to obtain.

Mr. GILMAN. Because of its accessibility and the low cost.

Dr. WILSON. Yes.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. SHAW. Mr. Chairman, let me correct the record, if I could.

The law that I was reading from, I note that it went into effect the first of October. So, we are really in the first few weeks of its enactment.

I would like to, and perhaps you might correspond with us, to let us know how you see it progressing as you become more accustomed to it and as the time goes by.

Thank you.

The CHAIRMAN. Dr. Udell, you spent a lot of time talking about educating a mother during pregnancy and even before pregnancy

and the negative impact of the mother abusing her body and what effect it would have on the child, and that whole thread of thought just sounded so much to me like the Right To Life in terms of giving some protection to the unborn since they cannot make any decisions.

I really have never given any thought as to whether or not groups that advocate the right to life, whether or not they are active in this area, as you said, on television, talking about not necessarily not having abortions, but talking about the obligation to life.

Is there much talk about that with these groups in Florida?

Dr. UDELL. I spend a fair amount of time speaking to a number of different groups here in Florida, and I must say, I did not get much activity from the Right To Life groups when they find out that all I am going to talk about is the cocaine. I do not want to get into the issue of when does the human fetus become a human and the abortion issue and all that.

I would be glad to speak to them about just the cocaine issue, and I do not get invited.

The CHAIRMAN. Let me try it again. How could a group run away from the question, the right to what kind of life?

Dr. UDELL. I do not know.

The CHAIRMAN. It just seems like an agenda item, the right to be crippled, blind, disabled, the right to be returned to a home to be abused. What do you think?

It seems like a legitimate question, but I want the record to make it abundantly clear that none of my colleagues is associated with the question I raised.

Thank you very much.

Mr. SHAW. I would like to point out that our Chairman is a church-attending Catholic.

The CHAIRMAN. Please give some thought to other questions that you may have and I have promised to work with Congressman Shaw not only in preparing a document which is not intended to be a political document for the Governor, but to work with the local state legislatures to see whether we can focus more attention on this child who cannot vote and is not really a political power anywhere, and we can see whether we can give him or her a little help.

Thank you very much for your dedication.

Dr. UDELL. Thank you.

Dr. WILSON. Thank you.

Ms. MARCH. Thank you.

[The prepared statement of Ms. March appears on p. 106.]

The CHAIRMAN. The next panel has the Deputy District Administrator for District 10 of the Florida Department of Health and Rehabilitative Service, Ms. Myra Lentz Bomba. The Executive Director of the Child Protection Team in Broward County, Ms. Patricia Neibel. Also Ms. Ruther M. Carter, Supervisor of Outreach and Adolescent Services, Broward County Alcohol and Drug Abuse Division.

If there is no objection from the committee members, then we will hear your testimony. I might add that you do not have to read it, if you do not want, your full statements will appear in the record. You may want to highlight it or talk in a way that makes

you feel more comfortable than reading, but you may proceed how you please.

Ms. Bomba.

TESTIMONY OF MYRA LENTZ BOMBA, DEPUTY DISTRICT ADMINISTRATOR, DISTRICT 10, FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, ACCOMPANIED BY CORA BRAYNON, NURSING DIRECTOR, PUBLIC HEALTH UNIT; LYNETTE BEAL, PROGRAM MANAGER, CHILDREN, YOUTH AND FAMILIES PROGRAM; VIRGINIA HOWARD, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PROGRAM; AND SHARON GOODWIN, CHILDREN'S MEDICAL SERVICES PROGRAM

Ms. BOMBA. I am Myra Lentz Bomba, and I am the Deputy District Administrator for HRS, and believing that none of us is as smart as all of us, I have brought some of my staff along that you might want to direct your questions to as we proceed.

Lynette Beal, who is Program Manager for the Children, Youth and Families Program in HRS. We have Cora Braynon, who is the Nursing Director for the Public Health Unit, which is also a part of HRS. We have Virginia Howard, who works with the Alcohol, Drug Abuse and Mental Health Program. And we have Sharon Goodwin, who works with the Children's Medical Services Program, which all of these individuals are the experts in their particular field, and I am the generalist who gets to direct all of this fine staff.

Thank you for giving me an opportunity to talk with you today. I will read portions of my statement and probably make some aside statements as I go along.

In the latter months of 1985, a form of cocaine known as "Crack" became popular with drug users in big cities around the country. By the middle of 1986, its effect was being felt throughout Florida and particularly in the Southeastern counties along the famous Gold Coast.

Broward County identified as a Gold Coast county, generally associated with wealth, beaches, yachts, waterfront mansions, swaying palm trees and beautiful sunsets, has its share of economic, social and health problems.

Even before crack cocaine use became epidemic, publicly funded agencies, such as the Department of Health and Rehabilitative Services, were already over-burdened with trying to keep up with the increased demand of service that comes as a result of being one of the fastest-growing areas in the country.

Just this morning, I heard over the radio that we are now the fastest-growing county, and I think we lost that distinction maybe for a year or two, but now we are back as the fastest-growing county with a nine percent increase in population over the last year.

We have an estimated population of 1.2 million people and Broward is currently the second largest county in the state. Dade, Broward and Palm Beach Counties combined comprise thirty-four percent of the state's population.

All of the problems associated with large metropolitan areas of the country can be found here. High infant mortality, high sexual-

ly-transmitted disease, high cocaine use, and all of the other things that society deals with on a daily basis. But it is compounded by Broward being a port of entry for illicit drugs from other countries.

The Department of Health and Rehabilitative Services is organized into eleven districts, and District 10 is the only one-county district in the state comprised of Broward.

The Department has broad statutory responsibilities which both directs and limits the provision of health and social services in the state with each district functioning within state rules and regulations in the implementation of programs at the local level.

All HRS Programs, which include Children, Youth and Families, Developmental Services, which again is involved with placing these infants as they grow older and the developmentally disabled, and we have to deal with those children as they grow older. Children's Medical Services, that the neo-natal intensive care unit is one of their programs and is one of their contract services.

Public health, that I mentioned to you, Alcohol, Drug Abuse and Mental Health, Medicaid, which picks up the funding for a lot of these families, Economic Services, of course, which provides services to women with dependent children, and Food Stamps and those other programs, and we also have Child Support Enforcement, which also gets its shot at absent fathers.

But, specifically, one of the areas that I as a public health nurse, with the public health nursing background, and twenty-six year employee of the Department of HRS, and a forty-year resident of Broward County, my concern and concern over the years has been the high infant mortality in Broward.

In spite of organized efforts through several grants from the Maternal and Child Health in the Social Security Amendments, additional state dollars for improved pregnancy outcome, and additional county appropriations, our infant mortality rates here have been consistently higher among the non-white population than the state as a whole, and also in comparison with other Southeastern states.

The CHAIRMAN. Ms. Bomba, could you try to tie in your testimony with the specific problem that we came down here to review?

Ms. BOMBA. Yes. I am trying to set the stage, Congressman, to say that the crack cocaine problem has been superimposed on an already overburdened system, and my point is that any time you have a new problem, such as AIDS in the country, and such as crack cocaine, that it places an additional burden on any kind of social service system that you have in place, and it takes awhile for Congress and state legislatures to catch up with passing legislation to deal with the new problem.

So, my point is that in addition to problems already in place, that we had the additional problems of crack cocaine and AIDS and this area has increased sexually-transmitted disease.

So, in July of 1986, Congressman Shaw, as a member of the Select Committee, did come here and did tour the neo-natal intensive care unit with Brian Udell and, today, as a result of that, you are sitting here listening to testimony.

The community network that was developed as a result of Brian Udell and many other community agencies who were dealing with the problems that you heard him describe this morning is what I want to talk to you a little bit about.

With the increase of the number of babies addicted to the drug, we started a cocaine babies work group in the fall of 1986. I think it was after a letter that Congressman Shaw wrote to then-District Administrator John Stokesberry. We met together on an informal basis rather than in an official way because of the statutory limitations and the right of the mother that you heard discussed earlier. We started a work group that would try to deal with some of the problems that you heard described by Ms. March and Dr. Udell and the other physician that was here.

One of the things that we found was that the need for additional staff in the area of Ruther Carter's program and with drug abuse residential programs in the area. The procedure that was developed included a follow-up program on an informal basis of the public health nurse to visit these babies. Later Secretary Coler did issue a departmental policy that was effective March 9th of this year, which mandated a system of identification, reporting and provision of needed follow-up services to the drug or alcohol involved newborn and to the mother who was identified as addicted.

A copy of this policy is included in your packet of materials. The major difference in our previous informal system of follow-up and the departmental policy was the implementation of a specific time frame for follow-up and doing the home investigation that Ms. March mentioned.

Since implementation of the policy in March, which, until September 30th, which is just a little over six months, the public health unit received some 400 at-risk referrals from six referring hospitals. The largest number of referrals came from Broward General Medical Center.

Of the 400 referrals, a 164 were to infants born to mothers with the history of substance abuse and had the positive laboratory tests. Out of those 164 infants, twenty-eight were referred to what we consider single intake for investigation of potential neglect.

It is also interesting to note that out of that 164 babies who needed intensive follow-up, only sixty-five of the mothers had received pre-natal care, and I think that is significant because it only serves to support the testimony by Dr. Udell that, you know, the women who need pre-natal care the most are the ones least likely to receive it.

So, the contact, the initial contact to the mother by the public health nurse is made prior to discharge from a hospital whenever possible. Otherwise, the public health nurse visits the mother's home within forty-eight hours post-discharge of the infant, and it is felt that the activity of home visiting to the home is of help in getting this baby taken care of.

One of the most troublesome problems, and it was mentioned earlier, is the place for these people to go. Sometimes the mother does not have adequate housing. She lives with another relative. Her grandmother, aunt or someone. And even when a relative assumes responsibility for these infants, often the infant goes into an already over-crowded in that home.

Another problem that has already been mentioned has to do with the legal custody problems of the care-taker that cannot give permission for the infant to have the necessary medical health care. So, establishment of legal custody even temporary is a long

process, and the availability of in-patient beds at drug treatment centers is limited. The time required to follow-up these infants has been a problem, and I want to tell you that there have been no additional funding for the follow-up programs that have been made necessary for follow-up because of this new problem.

Mr. GILMAN. If I might interrupt, who provides the funding for your agency?

Ms. BOMBA. We have three levels of funding. Federal Government, State government, local government.

Mr. GILMAN. And all of those have turned down the request?

Ms. BOMBA. The appropriations come to our agency for follow-up, but I was speaking specifically to deal with, Mr. Gilman, to deal with the crack cocaine problem. We have funding for follow-up and we have funding for abuse and we have funding for some other problems, but with the additional burden of crack, there has been no specific allocations for follow-up.

The CHAIRMAN. Has there been a specific request?

Ms. BOMBA. Yes.

The CHAIRMAN. And where would that proposal be?

Ms. BOMBA. It would be one of the legislative proposals to the state legislature.

The CHAIRMAN. But when you said that your resources for funding is local, State and Federal, where would you physically have placed that proposal?

Ms. BOMBA. Well, your committee, I am sure, the congressional money that comes down through Alcohol, Drug Abuse and Mental Health, also is used in some of the programs for prevention and also some of the——

The CHAIRMAN. Ms. Bomba, we have just increased the Federal funds, and that is why I am trying to find out. We have increased the funds because of an increase in the problem. You are the one on the front line and we are trying to find out where the Federal taxpayer dollars are going.

Where did you place your proposal for increased funding?

Ms. BOMBA. Well, the local proposal was submitted to the legislature. We got——

The CHAIRMAN. Hold it there. The local legislators are just like we are.

Ms. BOMBA. Yes, sir.

The CHAIRMAN. So, are you saying that once the money comes to Florida, that the legislators decide how to spend the Federal money? Who allocates your funds?

Ms. BOMBA. The State allocates to the different districts the HRS money.

The CHAIRMAN. And the legislators determine the amounts of federal dollars that will be appropriated?

Ms. BOMBA. I cannot answer that. I do not know whether the legislature does that or not. But I do know the Department of HRS prepares the legislative request for funding for all of the programs.

The CHAIRMAN. Okay. But you understand what I am asking. If we allocate Federal dollars and we come to a town and try to get Clay Shaw re-elected saying he brought his Federal dollars and you are saying that you do not know where the Federal dollars are.

Ms. BOMBA. No, I am not. I do not think I am saying that I do not know—

The CHAIRMAN. You are going to the State legislator to ask for the Federal dollars.

Mr. LEWIS. Mr. Chairman, if I may, the Federal allocation is provided to the state and then her organization, the Department of Health and Rehabilitative Services, makes the judgment as to how many dollars due on the previous history would go to the various districts within the state. So, she goes to the State for her Federal dollars.

The CHAIRMAN. But it would seem to me that, unless Florida is that much different, and having seen your gun laws, you may be, but it seems to me that she would go to the state agency in the executive branch with a proposal and that it would be the director of the state agency that would go to the State legislature saying this is what we would want for our budget.

Mr. LEWIS. That is exactly what does happen, and Secretary Collier does that when she makes a request.

The CHAIRMAN. Well, I cannot put a handle on the State legislators, but whoever is in charge of her department is the one that should take into consideration the fact that we just passed a $2.7 billion drug bill.

Ms. BOMBA. We do get drug money, sir, but what I think my point was, that crack cocaine is such a new problem that the language does not speak specifically to that, but speaks to the drug problem in general.

Mr. GILMAN. Why should it not speak to the drug problem in general?

Ms. BOMBA. You know, it should, it should.

Mr. SHAW. I think there is another question here that the Chairman was getting to, and I think this is something that the Federal Government ought to be concerned about.

We put money into certain areas, specific areas, because we feel that more money needs to be spent in those areas, and I think one of the things that I would like to know, perhaps you can find out and supply us with that information, is the State of Florida pulling back on the state share and letting the Federal portion backfill because that is not the intention of Congress.

The intention of Congress is to add the Federal funds to the State effort, and I think that is very valuable information that we will need in Washington. So, perhaps you could supply that.

The CHAIRMAN. Please understand, Ms. Bomba, we will not be able to track the Federal dollars through the state legislative body even though they may control your appropriation, but we want to hear from whoever is in charge of providing treatment and rehabilitation on the State level as to where are those Federal dollars, and as Mr. Shaw has pointed out, if we are going to find that the states are removing their dollars and replacing them with Federal dollars, then we have not done anything in Washington.

Ms. BOMBA. I do not know that.

The CHAIRMAN. Well, it is going to be helpful that you find the answers and we will leave the record open, but you can understand that we are not going to city councils and to State legislators

asking what are you doing with the Federal dollars. We have to go to mayors and to governors.

Thank you.

Ms. BOMBA. I understand.

The CHAIRMAN. We would want to have an opportunity to continue questioning. We have two more panels and, so, if the witnesses would know that their full statements are in the record and that we have been filled in with your backgrounds, if you could really target in on this problem that we are dealing with this morning, it would help the committee members really to ask the questions so that when we leave here, we can try to do something concerning the problems that you are facing.

Ms. BOMBA. Perhaps I should go then to a recommendation that I feel needs congressional attention, and that is the need for universal maternity care programs which would ensure access for all women, regardless of income, I think that is an issue that needs to be addressed.

I think that is one of the problems. You mentioned again the adequate funding to address the nationwide problem, and also locally the residential drug treatment programs which I am sure Ms. Carter will mention, and the other thing that is transcendental to this is the availability of low-income housing for families, for young families.

Thank you.

[Statement of Ms. Bomba appears on p. 109.]

The CHAIRMAN. Thank you, Ms. Bomba. Ms. Neibel, the Director of the Child Protection Team.

TESTIMONY OF PATRICIA O. NEIBEL, EXECUTIVE DIRECTOR, CHILD PROTECTION TEAM OF BROWARD COUNTY, INC.

Ms. NEIBEL. Mr. Chairman, you were not far wrong when you joked about cruelty to dumb animals. Ninety years ago, the first case of child abuse came into the City of New York as a case of cruelty to dumb animals when a man was consistently beating his daughter and the only way they could get the daughter removed was under that act of cruelty to dumb animals, and then the New York Legislature looked at it and did something. So, here we are, ninety years later.

We are the crack capital of the country, but our problems are going to be your problems in the future. I have a letter here I received from the Visiting Nurse Association regarding a two-year-old child, burns on his right thigh and right abdomen from a curling iron that had been completely healed, the child had been hospitalized. He is being neglected. He is sleeping in a bed with his sister, cousin and mother. He is dirty. His nail beds and feet had crusted dirt on them. His diaper was saturated with urine and stool. His mother said she tried to bathe the baby. She found broken bottles and glass in the front entrance to the kitchen area, pathways were blocked with piles of clothing and garbage. The bathroom was out of service and was stacked with dirty clothes. There was no other bathroom.

The kitchen was possible evidence of crack cocaine use. The counter top had numerous burnt-out areas, candles, matches,

ashes, burnt towels lying about. These are the paraphernalia of crack cocaine. I did not find any evidence of food in the kitchen refrigerator. The mother said she fed the child rice to keep his belly full.

So, here we have the life of a two-year-old in this community. He is hospitalized with burns from a curling iron. He is living on a rice diet. He is a toddler walking barefoot through a house full of garbage and broken glass, and his mother is stoned to sleep and he has no supervision.

Now, the Child Protection Team does not handle all of HRS cases. We only handle the worst ones. We handle if a child is hospitalized due to abuse, if the sibling died of child abuse, very non-ambulatory children, children and infants under the age of four, and other cases which HRS finds difficult and complicated.

We have a series of experts, board-certified pediatricians, Ph.D. psychologists, and Ph.D. social workers, Master level psychologists and social workers and registered nurses, and what we do is we give them medical and psycho-social evaluation and recommend what to do about the child and the family.

We have not kept statistics on cocaine or substance abuse per se, but over the last couple of months, informally, the staff has kept track, and in seventy percent of the cases, one parent or another was a substance abuser, and between twenty-five and forty percent of the cases, we know they were using—the mother was using cocaine.

Now, children of cocaine users are at great risk of being abused because their mother's sense of reality is distorted. Her prime concern is supporting her habit. She does not have time to look after her child.

A cocaine user needs to maintain a certain level of high. In the beginning, when she starts using cocaine, one line of cocaine will supply that high. She will get high enough on the one line of cocaine. As her system becomes acclimated to it, to maintain that same level, she will need five lines of cocaine. So, now, her child has five problems.

He has a problem that his mother is stoned. He also has a problem that his mother is very pre-occupied getting five times as much money to buy the cocaine. So, he is really neglected.

The problems we encounter range from failure to thrive children, children that are fed any old thing as long as it is easy from potato chips to rice to grabbing a wet, soiled crying baby and flinging it against the wall and killing it, and we have had that.

But, generally, it is a problem of neglect. The child is deprived of food, deprived of medical care, ignored, has emotional abuse, and there is a lack of bonding and there is certainly little love.

What can we do to prevent children from growing up in a sordid environment? We decriminalized alcoholism. The public decided alcoholism was a disease. We all accept that fact now, that it is a legitimate disease. Cocaine addiction is also a disease, and once the person is addicted to it, they have just as hard a time to get out of it as the alcohol-addicted.

Now, we have years of experience in treating alcoholism and rehabilitating alcoholics, and we can put that experience to work with the same type of program for the user. Now, I am not in any

way suggesting that we not go after the people in their Maseratis who are the cocaine bosses in this community or the rest of the country. I mean, you can lock them up or bury them at sea. Anything.

But I am talking about the plain stupid innocent user of cocaine, who is addicted as an alcoholic is addicted.

The CHAIRMAN. Is this your department's view or just your individual view?

Ms. NEIBEL. It is the department view, sir.

The CHAIRMAN. Have you written any papers on this?

Ms. NEIBEL. No, we have not. We are a very small department, and in the six years that we have been here, our case load has gone from 200 to 2,000.

The CHAIRMAN. Well, have you given testimony on decriminalization?

Ms. NEIBEL. No, no, we have not.

The CHAIRMAN. Is this the first time that you have expressed this view of the department?

Ms. NEIBEL. Yes, it is. It is something that until this committee was coming down here, we did not really sit and think of and discuss in a brain-trust-type meeting.

The CHAIRMAN. But do you not attend national conferences with your peers and discuss these problems?

Ms. NEIBEL. Yes, I do, sir.

The CHAIRMAN. Has the question of decriminalization ever come up while you were there?

Ms. NEIBEL. No. Not in a meeting that I have been at. I know it is a radical feeling.

The CHAIRMAN. Well, you might want to give some thought to the consequences of the radial view because I think it is just a little too easy to associate it with the problems that we have with alcohol abuse, but if you talk about innocent victims, I assume you would want to make the drug available to these so-called innocent victims.

Ms. NEIBEL. No, sir. I do not mean to make cocaine available to them any more than I would give an alcoholic a drink.

The CHAIRMAN. What do you mean when you say decriminalize?

Ms. NEIBEL. Treatment, massive treatment, of their problem.

The CHAIRMAN. Well, we want to do that, and you do not need to decriminalize to give massive treatment, do you?

Ms. NEIBEL. No.

The CHAIRMAN. So, why do you not tell me what you mean when you say decriminalize?

Ms. NEIBEL. What we do not want is for them to go underground. We do not want them to have their babies in the back rooms.

The CHAIRMAN. From what I have seen this morning, they are not having their kids in the back rooms.

Ms. NEIBEL. No. They are what we call drop-ins in this hospital. They drop in and have a baby. There is no pre-natal care.

The CHAIRMAN. Do you believe that by decriminalizing cocaine the mothers who are abusers will be forthcoming? Do you believe that the fact that selling cocaine is a crime?

Ms. NEIBEL. Yes.

The CHAIRMAN. Is this what is stopping these mothers who are using it from coming forward?

Ms. NEIBEL. No, sir. I am afraid——

The CHAIRMAN. What good would come out of it? What are you suggesting?

Ms. NEIBEL. What I am suggesting is that we not take the baby away from the mother when it is born, really.

The CHAIRMAN. Is the child being taken away because it is a crime to use cocaine or because the mother is irresponsible?

Ms. NEIBEL. Because the mother is irresponsible.

The CHAIRMAN. OK.

Ms. NEIBEL. What I meant by my suggestion——

The CHAIRMAN. What good would happen if we—you are not talking about making it legal. I do not know what you are talking about.

Ms. NEIBEL. No, I am not talking about making it legal at all. What I am talking about——

The CHAIRMAN. What do you mean when you say decriminalize?

Mr. SHAW. I think, Mr. Chairman, she is not using the word in the sense that we generally do because I was kind of shocked by that phrase, too.

Ms. NEIBEL. I think perhaps that is the problem. Semantics, Congressman.

The CHAIRMAN. Well, I will act as though it does not mean what I thought it meant, and we will leave it alone.

Ms. NEIBEL. Okay. As far as prevention is concerned, everyone I have talked with says education is it, and I know Dr. Udell says we do not educate, that the parent who is pregnant, but we should educate everybody everywhere, the school, the church, the beach, everywhere.

Every doctor's office in this country could have a mimeographed form and when a pediatrician sees a teen-ager, he can hand him this, he does not have to say do you, are you addicted to smoking, to alcohol or cocaine. This is it. This is where you go for help to everyone that comes in.

Every obstetrician does not have to ask the question. He can say here is the place to go and hand everybody these things, whether they are a person themselves that is addicted or a member of their family. The more the public knows about the problem, the more they can do something about the problems.

Mr. GILMAN. Ms. Neibel, is your agency doing anything in that direction?

Ms. NEIBEL. We are trying in a small way. We are an agency with a total of ten, including support systems.

Mr. GILMAN. Do you recommend it to the local government or state government, that they do something of this nature?

Ms. NEIBEL. No. We have just formed a board of directors who will be doing that and I serve on the Child Abuse Prevention Task Force, and we are doing things locally to educate parents and educate the public.

Mr. GILMAN. You say it should be more widespread. Have you made any specific recommendations to any group to make it more widespread, to reach out to more people?

Ms. NEIBEL. No. That is what I am hoping my board is going to do.

The national TV project that we now see that says "cocaine isn't cool" and there are top entertainers doing that, that could have a tag line of where to go for help for cocaine. Not just for the pre-natal mothers, but for everybody. This is a national program. It is fantastic. The tag line is a mini amount of money and I am sure the television stations would do that.

The CHAIRMAN. Where would they go in Broward County?

Ms. NEIBEL. That is our problem. We have very few places where they can go. They can go to—there are agencies that give alcohol treatment. There are agencies that give—there is Hialeah Hospital.

The CHAIRMAN. But if there is no where to go and they cannot get treatment——

Ms. NEIBEL. There is an excellent hospital in Miami in Hialeah Hospital. The treatment is about $7,000.

The CHAIRMAN. What are we talking about?

Ms. NEIBEL. We are talking about a middle class social worker with a son who is a crack addict who is twenty-seven and she makes $18,200 or $19,200.

The CHAIRMAN. We are here to try to deal with some of the problems that we found in this hospital, and I am certain that the mothers of these kids that we saw today would not be able to get to this hospital that you are talking about——

Ms. NEIBEL. No, they could not afford it.

The CHAIRMAN [continuing]. For treatment. So,—but what we are trying—look, we know how broad the problem is, but we are trying to see whether your agency or any other agency could give us some assistance as to what we should be doing in the Congress to avoid these type of tragedies that we are seeing here at this hospital——

Ms. NEIBEL. The kind of——

The CHAIRMAN [continuing]. And to tell someone that they can get $7,000 treatment in Miami is not exactly—does not leave us feeling that we have made a contribution here.

Ms. NEIBEL. No, and I point that out only that the middle class cannot afford it either.

The CHAIRMAN. But, I mean, why tell someone where to go for help if you do not have a place to go?

Ms. NEIBEL. We do have area agencies here.

The CHAIRMAN. It is just like calling a suicide number and having a busy signal.

Ms. NEIBEL. The health department surveillance really is not enough. I am the first—you know, after the birth of a cocaine baby, what are you going to do? Generally, very often, we remove the child, but the State of Maine was very successful in an intensive TV campaign they put on, and they are not a wealthy state like we are, they had a TV campaign on pre-natal care. They gave away a free magazine. As a follow-up in the magazine, it listed free pre-natal clinics.

We could do the same but tie in a component in the magazine and the TV spot, in the magazine and in the pre-natal clinic, on cocaine addiction and getting rid of it.

The CHAIRMAN. OK. Ms. Neibel, the recommendations that you make, as Mr. Gilman said, should really be done to the local and

state authorities and the churches and the synagogues and trying to get more people aware.

What we are trying to do is to see what we can do in the Congress. We have appropriated money. We are trying to track that money. We want to see how it is being used. What is happening with it and that type of thing, and like I said, Congressman Shaw is going to be working with the city council people and the state legislators and the governors so that you are not just left out there, but that will not help us too much, you know.

Ms. NEIBEL. No. We have one person doing twenty hours a week of going around educating in the churches, wherever two or three are gathered together, but that is not enough. If national TV, and you people have the clout, not us, you can go to people, the producers of NBC and CBS——

Mr. GILMAN. If I might interrupt, we did encourage the filmmakers to do just that and along with Mrs. Reagan they did agree to it and that is why you have these trailers in the movies that show the drugs as a tool and that is why the advertising media have engaged in this.

The question the Chairman is asking you, when you ask for a tag line, where do you go if you put a tag line on, and that becomes a local problem. You have got to develop these centers if you want to provide that kind of information. Sure. We can ask them to put a tag line up, but make certain that you do have a facility available to do what you are asking them to do.

Ms. NEIBEL. I think when we have a mother who is seriously addicted and the health department cannot help, they make a call, they find a mother that is stoned, they could pick up the mother and the child and put them in one facility. We do not have it now.

Mr. GILMAN. But that is the point. You have to develop that kind of local resource if you want to encourage them to reach out for that help.

Ms. NEIBEL. But we have to know it in the community, that that is a viable source.

The CHAIRMAN. What you are saying would make sense if you had these clinics and no one was going to the clinic, you know, but you have got the opposite problem. People are not going because they know or they believe that no one is going to care, and it is not just your town, it is mine, too.

So, you know, we cannot tell people that we are here to help and then they say they want it and then we say, you know, there is a two-year waiting list.

Ms. NEIBEL. Yes. We have two-year waiting lists. We have months and months of waiting lists to get into some of the agencies in this community. What I am advocating is an in-house facility where the mother comes in with the child instead of putting the child in foster care and the mother in a treatment facility, put them in together.

As soon as she is detoxed, have the mother take care of the child.

The CHAIRMAN. Who have you told this to before we came to town?

Ms. NEIBEL. We have discussed it at Children's Medical Service.

The CHAIRMAN. OK. Well, you make certain you get in touch with them, Congressman, and say it makes a lot of sense, okay?

Mr. SHAW. Have you made a recommendation to these agencies?

Ms. NEIBEL. No, I have not made a recommendation.

The CHAIRMAN. You do some of that and let Congress know what we can do.

[Statement of Mr. Neibel appears on p. 126.]

The CHAIRMAN. Can we hear from Ms. Carter with Outreach and Adolescent Service Program?

TESTIMONY OF RUTHER CARTER, M.S., C.A.C. (CERTIFIED ADDICTIONS COUNSELOR), SUPERVISOR OF OUTREACH AND ADOLESCENT SERVICES, BROWARD COUNTY ALCOHOL AND DRUG ABUSE DIVISION; ACCOMPANIED BY MARIE REYNOLDS, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG ABUSE DIVISION

Ms. CARTER. I am Ruther Carter, and I am with the Broward County Alcohol and Drug Abuse Services Division.

Cocaine and cocaine abuse is a problem. The pleasure that arises from cocaine lasts only five to seven minutes, and we feel that people who abuse cocaine are addicted to the drug. We have found that here in Broward County crack cocaine is a highly addictive drug.

The availability of crack cocaine and the accessibility to it have caused many problems, and it has impacted heavily on families, especially pregnant mothers. Some mothers deliver their babies having used cocaine throughout their pregnancy, and go right back to abusing cocaine as soon as they leave the hospital. Since crack cocaine is such highly addictive drug, as Ms. Neibel mentioned, cocaine addiction can be viewed as an illness. We feel that anything that can cause addiction so rapidly presents many serious problems. One of the biggest dangers of using crack cocaine is that it may become the most important thing in a person's life. When this happens, relationships with family and friends may suffer. We feel that it is an addictive drug that affects the entire family.

I also have Ms. Marie Reynolds, who is Executive Director for the Alcohol and Drug Abuse Division, for any questions in terms of funding that I cannot answer today, she is in the audience and I am sure she can accommodate me with whatever questions that you might have.

I would like to point out that we work closely with HRS, with Myra Bomba's office, and all the health service programs in this county. We are a county agency, and we also work closely with Broward General Hospital. We have been working in the past with the task force to take a look at the problem because cocaine abuse is rapidly escalating here in this county.

We are concerned about the mothers. What we have done is to target these mothers and place them on our Outreach Unit. The Outreach Program is the arm of BARC that reaches into the low income and minority communities for the purpose of identifying persons who are in need of services. We alert persons and their families to the availability of the services, locating needed services and helping persons to enter and accept the services delivery system. This unit operates out of BARC's main facility and neighborhood multi-purpose centers within the cities of Hallandale, Hollywood, Dania, Fort Lauderdale, and Deerfield Beach.

Our goal at BARC is to inform, to educate and to treat people with substance abuse addiction. This is why our office has been working so closely with the agencies in this county, to see what we can do.

I have submitted a written report, however, I would like to point out some of our statistical findings. For example, we have had 146 referrals and walk-in for services, 32 came for treatment during their pregnancy, 57 dropped out of treatment within thirty days, 55 completed 90 days in treatment. At this time 25 mothers are actively involved in treatment. I have highlighted crack cocaine because it has embedded itself so deeply in this community, that it has caused a heavy impact on our system as a whole.

We have a medical detoxification unit right in our facility. This 35-bed unit offers medically-supervised withdrawal from the effects of alcohol or other drugs on an around-the-clock basis. The basic five-day program includes counseling and education. This unit, however, is unable to accept pregnant woman who are abusing crack cocaine.

We have tried to do mass community education, to inform pregnant women in local neighborhoods about the dangers of abusing crack cocaine. Because they are so caught up in the vicious cycle of their addiction, crack cocaine users often do not know where to go for help. Many mothers who were referred to BARC after their babies were born came in for an initial assessment only. They came in because they felt pressured, but many did not return. We have not been able to follow-up on them as we would like to have done.

We do have an active case load of twenty-five mothers who are involved in their treatment and some of them have six to nine months sobriety. We have had fifty-five mothers to complete an intensive treatment within our comprehensive system. They were in treatment for 3 to 6 months. Many parents are calling from the community asking for help. "My daughter is pregnant. She is five or six months pregnant and, she is in this vicious cycle of crack cocaine. She is stealing. She is abusing the baby. She is doing things, and I cannot do anything about it. I do not know what to do. Tell me what to do, where to go."

Well, that is kind of where we are.

The CHAIRMAN. What do you tell them?

Ms. CARTER. I tell them to come in for help. I give them information on crack cocaine, and explain how the intensive highs affect them. Also, we tell them how to get off crack cocaine and how difficult it is to stop using. Crack is a very potent form of cocaine and there is growing evidence that cocaine increases the risk of miscarriage, premature birth, stillbirth and having a baby who is born addicted.

Over the eighteen years that I have been working with substance abuse, crack cocaine has been the most drastic form of addiction that I have seen in all my years of professional work.

I tell them to come in for treatment simply because we are a comprehensive system, to inform and to help them. Many people get lost because they do not know where to go. I bring them into the office and the staff works with them. The one thing we do with the pregnant mother is tell them that crack cocaine is deadly. There is a system set up through the HRS system to be referred to

the health department so the client can get some pre-natal care and come back to us for some out-patient treatment and support services.

The CHAIRMAN. How many people are on your staff?

Ms. CARTER. We have three staff members specifically working with this project. We are anticipating that by November 1 $100,000 will come in from the state H.R.S. office through Children, Youth and Families Services to work and to highlight this particular program.

Now, Outreach Program itself has ten staff members, and they are all trained in substance abuse to track and assess mothers who come in who are abusing crack cocaine or other drugs.

The CHAIRMAN. Well, how many people do you supervise?

Ms. CARTER. I supervise ten people at the present.

The CHAIRMAN. And how many offices do you have?

Ms. CARTER. I have six in the community.

The CHAIRMAN. Now, if you have six offices and ten people, what are these, one person offices?

Ms. CARTER. One person per office. What we do is satellite the services in the already-existing health service office in neighborhoods. An example, in one office, we have primary health care, social services, employment, Red Cross and other Human Services.

The CHAIRMAN. Are these offices located in areas of high drug abuse?

Ms. CARTER. Some of them are located in high drug abuse areas and some of them are located in central locations between different communities.

The CHAIRMAN. When you say ten people, does that include the three staffers you were talking about on the special project?

Ms. CARTER. That includes the present staff. We are hoping to hire three more people once we get this money we are anticipating by November 1.

The CHAIRMAN. And you work for the county?

Ms. CARTER. County. The county has a multiplicity of services. We have a detoxification service that stays open around the clock, nursing and medical directors and etc., an out-patient unit and an Outreach program. We also have a twenty-bed intensive residential treatment program.

The CHAIRMAN. But you do not supervise that?

Ms. CARTER. No.

The CHAIRMAN. Well, what Ms. Neibel was talking about seems to be included in your recommendation; that is, a residential care and companion child care service. I think that is what she was saying was needed.

Ms. CARTER. Yes.

The CHAIRMAN. Now, are you saying you have it or you are recommending it?

Ms. CARTER. No. I am recommending it because pregnant mothers have not been accepted into our system's residential services because of the medical complications that they can encounter in terms of their pregnancy.

So, what I am recommending is that a special program be set up for pregnant mothers who are sleeping in the street or living in the street and have no where else to go.

Mr. SHAW. How prevalent is that problem here in Broward County?

Ms. CARTER. It is high.

Mr. SHAW. Pregnant women living in the streets?

Ms. CARTER. Pregnant women living in the street, living in "base" houses. Many mothers who come into Broward General Hospital deliver their babies five minutes or ten minutes after using crack cocaine. They have no place to go. We have to network the whole health care system to assist the hospital in relocating them back into the community.

We will place women in the Salvation Army rehabilitation program after they have their babies and then turn around and have a case manager staff to assist them immediately in finding some other residential housing. We rely heavily on the extended family.

If you noticed in my report that a great deal of the referrals have been black women who come in for treatment. Within the black community, there is still that extended family that gives support. Grandmothers love their grandchildren in spite of what they have done and they will do what they can do to help support the system for their children.

My recommendation was that I felt many of the women were not coming in for treatment unless there was some court order over their heads to force them into treatment.

The present laws are good, but we have no law to force women to come in for a certain amount of time to get treatment. Ms. Neibel was mentioning the terms of involuntary commitment to treatment. I felt this was what she was addressing, to mandate mothers in through a court order.

Many parents call and ask where can they go to make their daughters come in to get some treatment. What court. The only act we have now is the Madan Act, or Myers Act where we can use that in our circuit court to get mothers to come in. I had three referrals just yesterday. That is what we are trying to do at the present.

I feel that we need an increase in Federal funds to provide the facilities once we do something with the law.

Mr. GILMAN. Have you asked for those—that increase in funds of any agency?

Ms. CARTER. Yes.

Mr. GILMAN. Who did you address that to?

Ms. CARTER. Ms. Reynolds, my executive director, I just went up the ladder. She in turn addressed the county and HRS. At the present, we have been meeting with HRS system and they, too, have sought out money for BARC. Community service council has been a great support to us.

Mr. GILMAN. They have denied the funds to you then, have they not?

Ms. CARTER. No. This is where we are anticipating the $100,000 to increase the services to these women.

The CHAIRMAN. Mr. Shaw.

Mr. SHAW. Just one question I have and I will just address it to the panel.

You have a crack addict, cocaine addict. He is in need of immediate service. Where does he go in Broward County and how long does he have to wait because he does not have any money?

Ms. CARTER. We opened up a ten-bed detox program to our present BARC facility and many of them come in. We do have a waiting list, but it is within twenty-four hours. The fee is on a sliding scale based on eligibility to pay. If they come in with no money, they still can receive the services.

We are just anticipating the opening of an out-patient detox to assist some of the cocaine addicts who might not need our present "detox", but can use some expanded services to assist them in motivating them to other services.

[Statement of Ms. Carter appears on p. 131.]

Mr. SHAW. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Gilman.

Mr. GILMAN. Thank you.

Panelists have exclusively gone over these good programs that you have, but it seems to me that all of your recommendations are addressed to what could be or should be done at the local government level.

I do not recall hearing all three of the panelists mention anything that is truly needed at the national level. It is on the national level that we have made some additional funding available, and I think it is a matter of allocation at the state level and county level as to how these funds are being utilized.

You sound like you have some good programs out there and the need for some additional programs, but all of these, I think, can be addressed at local government level. Am I wrong in saying that?

Ms. NEIBEL. In a small degree, you are wrong. We both agree that television spots are fantastic. We should get television programs, like "Family Ties" and "Murder, She Wrote", things like that, to address the family interaction and dynamics when there is someone abusing, so the family can recommend——

Mr. GILMAN. All right. I agree that that is something we can do at the Federal level. We have done some of that.

Ms. NEIBEL. I know you have.

Mr. GILMAN. We are doing a lot more of that, but tell me about any programs where we can help with this problem that we are seeing here today at the hospital with regard to helping pregnant mothers with their drug abuse.

What can we be doing more of that we are not doing already? That is, I think, the focus of our hearing, and I have not heard any needs expressed at the federal level from this panel.

Ms. BOMBA. Could I ask Virginia Howard on the drug abuse and mental program to come up?

Mr. GILMAN. Sure. Come on up.

Ms. BOMBA. To speak specifically about the amount of drug money that we get into the area and how—whether or not she feels that that is adequate or whether or not she feels that—Mr. Gilman. But in doing so, I would like to know who you have addressed your requests to and what the response has been.

Ms. HOWARD. Well, our District 10 received about $450,000 of Federal drug monies, specifically designed and targeted for programs to address the crack problem.

Mr. GILMAN. And who did you receive that through? What agency?

Ms. HOWARD. Through HRS in Tallahassee.

Mr. GILMAN. Right. And they decided how much money was to go here to Broward County?

Ms. HOWARD. Right.

Mr. GILMAN. But was that limited from the Federal Government or was it——

Ms. HOWARD. Well, we were allocated a certain amount and there was certain parameters.

Mr. GILMAN. The fact is it was given to the state.

Ms. HOWARD. That is right, and we received almost twenty proposals from our agencies, and we decided to divide the money in half, about $225,000 went to adults, most of it went to Ruther's program at BARC for drug detox beds. Another portion of it went to Spectrum, another drug rehab center.

Mr. GILMAN. All right. If I may interrupt, is there more money this year than last year?

Ms. HOWARD. This was a separate allocation.

Mr. GILMAN. That you had not received last year?

Ms. HOWARD. Right. New money.

Mr. GILMAN. $450,000 in new money. Is that what you had requested from the state?

Ms. HOWARD. I do not know whether it was requested. This is certain amount was allocated to different states, then the state legislature in Tallahassee gave us a certain amount.

The CHAIRMAN. Will the gentleman yield?

Mr. GILMAN. I will be pleased to yield to the Chairman.

The CHAIRMAN. Did you expect that you were going to get three-quarters of a million dollars? $750,000?

Ms. HOWARD. Yes. We expected to get more money.

The CHAIRMAN. Okay. Now, what we are trying to do is not to cross-examine or except just to walk away feeling that we have learned something. What made you think you were going to get $750,000?

Ms. HOWARD. Initially, we were told we were going to get——

The CHAIRMAN. By whom?

Ms. HOWARD. From our office in Tallahassee, that we were going to get about——

The CHAIRMAN. That would be the state office——

Ms. HOWARD [continuing]. $650,000.

The CHAIRMAN [continuing]. Or the state HRA?

Ms. HOWARD. Yes.

The CHAIRMAN. Now, why did they tell you that amount was so dramatically reduced to $450,000?

Ms. HOWARD. Well, that it was held up in Tallahassee and the legislators decided that certain amount of money off the top were for other programs. So, our program was cut by $200,000. Our portion was cut by $200,000.

The CHAIRMAN. And when you got the $450,000 additional funds, that is in addition to what you normally would expect from the state, did you have to prepare a proposal to send to Tallahassee?

Ms. HOWARD. Our district received proposals from our providers regarding special programs, and, so, we looked over the programs,

investigated them, our staff discussed them, and put them on a priority basis.

The CHAIRMAN. What was the total amount requested for the proposals which you selected and gave priority to to Tallahassee?

Ms. HOWARD. If we had added all of the proposals, that would have been the amount of money we should have gotten in the beginning, which was about $650,000.

The CHAIRMAN. And then——

Ms. HOWARD. They funded most of the proposals.

The CHAIRMAN [continuing]. When they gave you the $450,000, did they tell you to find which programs you wanted——

Ms. HOWARD. Yes.

The CHAIRMAN [continuing]. Or—they did?

Ms. HOWARD. Yes.

The CHAIRMAN. Mr. Gilman.

Mr. GILMAN. And when you made the request for $650,000, had you sent all of these proposals to Tallahassee?

Ms. HOWARD. My experience was that they were giving us the money.

Mr. GILMAN. Well,——

Ms. HOWARD. It was Federal drug money that we would be receiving.

Mr. GILMAN [continuing]. You did not make a request for a specific proposal to Tallahassee?

Ms. HOWARD. No. I made specific requests for proposals from my substance abuse provider agencies.

Mr. GILMAN. You did not pass that on to Tallahassee; you said we need $650,000, is that right?

Ms. HOWARD. I was told that that was the amount of money we were receiving from our office.

Mr. GILMAN. Without any proposals going to Tallahassee.

Ms. HOWARD. Yes.

Mr. GILMAN. So, in other words, Tallahassee said Virginia, we have got $650,000 for you, you decide how you want to spend it?

Ms. HOWARD. Yes, sir.

Mr. GILMAN. And then you got the proposals together, but then you found out you only had $450,000?

Ms. HOWARD. Yes, sir.

The CHAIRMAN. That is exactly what we did not want when we appropriated the money. We had hoped that there would be innovative programs, such as many of the things that we heard about today, that we did not want to substitute state programs nor did we just want to have large amount of monies allocated by state and population.

We really had hoped that when the year was over, we could have heard what you were doing in Tallahassee, whether it would work in New York, whether it would work in Chicago, but when you find people who do not really want to enforce the law, this is what we find. It has just been cut up.

Mr. GILMAN. If I might just pursue this, you then divided up the $450,000 or whatever it was among seven projects, is that right? Seven or eight projects, whatever?

Ms. HOWARD. The top projects. One-half to the adults for detox and re-entry and the other half went to a delinquency diversion project for children.

Mr. GILMAN. That was all new money then that went out to these project centers?

Ms. HOWARD. Yes.

Mr. GILMAN. In addition to what they were doing. So, then, they all had additional funding, correct?

Ms. HOWARD. Yes.

Mr. GILMAN. And that includes these three agencies that are before us, is that right? Do they include these three?

Ms. HOWARD. No, no. She did not—Child Protection did not receive money. BARC received money.

Mr. LEWIS. Would you yield?

Mr. GILMAN. I would be pleased to yield to the gentleman.

Mr. LEWIS. I would like to ask a question, if I might.

Ma'am, when did you receive the $450,000?

Ms. HOWARD. Several months ago.

Mr. LEWIS. Okay.

Mr. SHAW. I believe Ms. Carter's ten-beds are all federal. I think they are out of the money that you are referring to.

Ms. CARTER. Yes.

Ms. BOMBA. You know, I think the problem here, Mr. Chairman, if I may be so bold as to make a statement, those of us who are sitting here work at the district level in HRS. We implement policy and procedure as set by the state department.

I am very sorry that Secretary Coler or one of his assistants at the state level is not here. He would have the answers and he would have the information that you are seeking from us.

The legislative budget requests and the allocation and the allocation formulas to distribute drug abuse money or any other federal appropriation is not set at this particular level. Now, I am not saying that we do not have input. We prepare what we feel at the local level are our legislative and program issues each year. We submit those in a package of the eleven districts that we have in HRS, submit those through our district administrator to Tallahassee.

Those are all looked at, I am sure, in a very, very comprehensive way. Then, those dollars that are available are appropriated as far as they will go to meet the needs of the communities that need them based upon the needs and statistics that we send forward.

So, I think you are asking questions of us, while we would like to be able to answer them, that we do not know exactly how the process works at the state level.

The CHAIRMAN. Well, let me tell you this, Ms. Bomba, we are here also to let you know how this process works, and it does not really help us while we are raising the nation's taxes and taking the risk in going against the President and going against OMB and going against Health and Human Services and we say in passing a bill, even though the President could have vetoed it, we said we were going to pass a bill, take the political heat, and get the money out there to our congressional districts, and then to find out that the front line troops, which are you, cannot identify where those Federal dollars are or not be able to go to the big shots in Tallahas-

see or wherever they are and say, listen, we know what the state legislators have appropriated, but we understand from Congressmen Shaw and Lewis and others that there is additional Federal dollars coming down here.

And, so, when you start allocating, if this is the center where there is a problem, you should put—feel free to put additional pressures on those people that have control over your budgets because if we find out that those dollars are not additional dollars, then we are going to have to have hearings in Tallahassee or in Albany or wherever we have to follow our taxpayers' dollars.

And, so, do not feel embarrassed that you do not have the answers, but, really, what does it mean if we tell you we passed a $3 billion bill if you are saying it is business as usual where you are?

Mr. GILMAN. Mr. Chairman, I am going to make a request that our staff make an inquiry of the State government to see what did happen to this funding and where this $450,000 came from and why they did not get the allocation that they had anticipated and what has happened to the Federal funding.

If we could make an inquiry of the State administration and make that part of the hearing, the response become part of the hearing, at this point of the hearing.

Just one other question. Did each of your agencies receive more funding this year than last year, whether they be State, local or Federal?

Ms. CARTER. Would you allow me to call my executive director up to answer the funding question?

Mr. GILMAN. Sure. Yes.

Ms. CARTER. Ms. Marie Reynolds.

Ms. REYNOLDS. Yes.

Mr. GILMAN. Ms. Reynolds, can you answer that? Did you get more money this year than last year?

Ms. REYNOLDS. Yes. We are one of the few agencies that got some of the federal money.

Mr. GILMAN. And how much more did you get this year than last year?

Ms. REYNOLDS. We got a $190,000 of Federal money. However, the state dollars increased by exactly three percent, and I think maybe you are asking for something that you could put into Federal legislation that would help us. I think that perhaps tying your allocation of Federal dollars into a requirement that the state add state dollars to it, as they did with the comprehensive alcohol program in the early seventies, that might be your handle, because last year this time, I am very seldom optimistic, I was really optimistic that all elected bodies were going to help us because we had so much media coverage.

The Congress did. The Florida legislature met and we got something called a price level increase of three percent. Three percent does not meet your existing salaries, if you want to give your employees a raise in pay. It does not hold us together. The county commissioner had to make up our shortfall on our existing program to keep us at the same level we were at last year.

Mr. SHAW. Let me ask you this then. I was going to direct this question to Ms. Carter, but perhaps you are the—I should address it to both of you. These ten beds that we are talking about, and

these were a direct result of federal funding through the Omnibus Drug Bill, would those beds have been in place anyway? Were they in place prior to that and what would happen to those beds after the federal funding goes away?

Ms. REYNOLDS. In anticipation of the Federal funds, the county put up some dollars early as a pilot program knowing they were getting them.

Mr. SHAW. How early?

Ms. REYNOLDS. March.

Mr. SHAW. Oh. So, it was after the passage of the bill. So, the money was in the pipeline.

Ms. REYNOLDS. Yes. In order to help us get going.

Mr. SHAW. But you did not have those beds beforehand?

Ms. REYNOLDS. No.

Mr. SHAW. So, there is a good side?

Ms. REYNOLDS. Yes, because our detox program historically had been alcohol detox, and because it was alcohol dollars. Legally, we could not treat drug clients. Certainly, we were. Legally, we could not. These ten beds gave us enough other funds in there to provide thirty-five beds, which are now all multi-addiction beds.

Mr. SHAW. Let me ask one more question with regard to that. I understand there is a problem as to the availability of these beds to pregnant women. What are the guidelines?

Ms. REYNOLDS. The problem is that we are running a minimal medical facility. We are not in a hospital. We have only so many things we can handle medically, and the concern of the pregnant woman coming off of cocaine and perhaps going into premature labor or aborting the child——

Mr. SHAW. The liability issues.

Ms. REYNOLDS. Yes, it is. It is.

Mr. SHAW. And the beds are closed to pregnant women or advanced pregnancies?

Ms. REYNOLDS. Yes. We are working on, you know, trying to go through the pre-natal care program, so forth.

Mr. SHAW. What is available to a pregnant woman who wants help?

Ms. CARTER. There is nothing. No residential treatment no where in this county and that was the reason for our recommendation.

Mr. SHAW. A pregnant indigent who is addicted has no place to go?

Ms. CARTER. No place. We spent a lot of time searching for a residential or out-patient treatment.

Mr. GILMAN. What percentage are homeless of the pregnant indigent women?

Ms. CARTER. Just on cocaine or just homeless?

Mr. GILMAN. Just homeless of your pregnant women.

Ms. CARTER. I do not have a direct percentage, but twenty-five percent of them at least.

Mr. GILMAN. Of your indigent pregnant women are homeless?

Ms. CARTER. Homeless with no place to go.

The CHAIRMAN. I do not see why they would not go on crack to be honest with you.

Ms. CARTER. Some of them, may I add, some of them are homeless because of their addictions. They have stolen their parents

clean. They have done a whole lot of other things, either they have sold their apartments, sold their clothes, sold whatever, and they are at the point in life where there is nothing left for them.

The CHAIRMAN. This has been a very educational panel, and I hope that our piercing questions, they were not meant to embarrass you, but to educate us and also to share with you that you are going to have to follow your Federal dollars without getting yourself involved with political problems in doing it.

But it does not make sense that we are voting programs and we do not see increases in the services which we know you would want to provide. I am asking staff, we ought to pick half a dozen States and Florida will certainly be one, to ask the Governors to show the flow of additional Federal funds with the various programs that we have here. But——

Ms. BOMBA. Just like ten beds. That is a drop in the bucket when you are talking about, you know, about the amount of crack. I mean, we had 400 referrals in six-months time.

Mr. GILMAN. Ms. Bomba, the Federal funds were not intended to substitute for State services, and what we are finding in your testimony and we are going to pursue it further is that apparently the state is substituting the Federal monies for what their responsibilities should be. It should be a sharing of both Federal, State and local.

Ms. BOMBA. I agree, Mr. Gilman, and, you know, as I have stated earlier, I have been in the system for a long time, and it is a constant—you know, when you are in a high-growth area, that to keep up with the everyday—just the everyday increase, regardless of crack cocaine and AIDS, you know, the number in foster care. I have Lynette Beal here. You know, we have only like 250 foster homes.

We have over a thousand children in foster care right now. Many of those homes are over-capacity. They are licensed for three foster children, and we have five foster children in there. We have six AIDS children right now.

Mr. GILMAN. We recognize, Ms. Bomba, if I might respond, we recognize the critical need. That is why we are here. That is why we provided that program. But, again, Federal funding was intended to supplement existing programs, not substitute for those programs. Somebody is not pulling their own weight here.

Ms. BOMBA. Yes, I understand.

The CHAIRMAN. We do not have a place for the homeless to go, and I am not talking about here, but in New York, and the women are pregnant and they are exposed to the drugs and they take the drugs and then they get pregnant. We are talking about spending millions of dollars in additional money because we did not spend a couple of thousand in preventing the problem.

And, so, it is not enough just a minister saying that the crisis is so big that all we can do is try to keep catching up; the reason we spend time not in our districts and going to other peoples' districts is to get ideas that we can take back to Washington to try to avoid this from happening in the first place.

You know, one of the places that it could be avoided, you know where the crack comes from? It comes from the cocaine. You know where the cocaine comes from? You know, it comes from Peru in

the coca leaves and you know who our Secretary of State is? You know, how much money we are giving to the Peruvians, the Colombians, and you know how much we are giving the Bolivians? Do you have any idea? It is more than you are getting.

All right. And you watch television. You do not have to go to Tallahassee to see Secretary Shultz, right? Is he on television? Against terrorism and communism and all of those isms. Has anyone ever heard him talk about this?

Caspar Weinberger is in the Persian Gulf, right? Have you ever heard him talking about dealing with these people that are bringing the drugs into the United States? I mean, if you want to get political, this is not the right group for me to get political with, but I am telling you that you have got to get involved. You have got to get involved.

There is no coca being grown in Florida. Okay. So far, there is no cocaine being processed here or any place in the United States. So, we cannot blame Tallahassee unless we are going to really check out whether we are on top of what is coming into our country, and we are not just here to find out the problems and leave.

If you come up with any ideas that you would want to suggest, we will have the record remain open. Meanwhile, we do hope that your next meeting with this people, you find out how much money was appropriated last year before the Congress acted, how much was appropriated this year after the Congress acted, and how much—whether or not the state contribution was the same or more than it was last year because even though we recognize it as a national problem, we also believe that there is local and state responsibility to deal with it.

This has been a very, very informative panel, and I want to thank Clay Shaw for his input in making certain that you were invited.

Mr. SHAW. Mr. Chairman, while this panel is leaving, I know that this hearing was not meant to be an oversight hearing as far as federal expenditures, but I think it is has shown the need for such oversight hearings for both state and local government as to exactly where these dollars are going, so that we can craft new bills that would require local and state contributions in the form of matching funds in some areas.

So, I think this is something that we have got to look into, plus I think that there is no question but that we need more accountability for federal funds from the receiving agencies and in this situation, we are talking about the state and local government.

The CHAIRMAN. Well, Mr. Clay, no one knows better than you that if we had gotten more cooperation from the Administration as to how they would want us to craft a bill, we were very, very anxious to do it. Unfortunately, this bill came out in two weeks and no help and we just did the best we could, but you are right. We should, Mr. Shaw, I am sorry, we should make certain that there is not a dimunition of local and state support. You are right.

Thank you very, very much.

Our next witness is here. I have to ask the photographers to make certain that she is not photographed from the front. Whatever happens from the rear is okay, but if there is any attempt to take any facial shots, it would be embarrassing to the committee,

to the witness, and we would have to ask the media to leave, which is certainly something we do not want to do.

Tom Lewis, I am sorry, did you have——

Mr. LEWIS. Yes, I do, Mr. Chairman, but I will ask them later.

The CHAIRMAN. Let me apologize. I am sorry. You should have felt free just to have interrupted before they left. But we will make it up before we leave.

Now, Sarah, we will call her a client of the Cocaine Mothers Program at BARC, has agreed to share some testimony with us and the photographers have promised to respect your privacy here.

We know, Sarah, it takes a lot of courage to come forward to share your views with us, but we would want you to know that by doing this, it might be helpful so that someone else will not have the same problems that you have faced.

We want you to relax, just take your time, take a deep breath, and just feel comfortable talking with us.

TESTIMONY OF "SARAH," A CLIENT OF THE COCAINE MOTHERS PROGRAM AT BARC [BROWARD ADDICTION REHABILITATION CENTER]

Ms. SARAH. Good morning. My name is Sarah, and I was a crack user while I was pregnant, and I just want to say that I am grateful today for the help of BARC and my minister. I have been rehabilitated and I am still fighting the battle against crack, but it is a very serious problem, and I was well educated and came from a decent family, but I fell victim to the crack in the streets and I had no one, nothing. I was pregnant.

I sold all my valuables and had misused and abused everyone that trusted me and I just did not care about anything or anyone, and due to the fact that I had a medical education, I still did not even care about the child that I was carrying and I continued to use cocaine and crack.

And I sought some help when I was about four or five months. I called different agencies, Spectrum, a couple of other agencies, including BARC, and no one could accommodate me because they did not have the facilities for women that were pregnant and on crack. Not an in-patient program. They had an out-patient counselling, but I gave up.

At that time, you know, I was not even thinking of the outcome of the circumstances concerning my child's birth. I was lucky, though. My child was born. She is very healthy. She is a beautiful baby and I no longer crave or want or even seek crack.

And I am just here to say that I hope by my coming, you know, before this committee today that it is something that can help prevent the women from using crack even before they become pregnant, so that they do not have to suffer, you know, the way I did.

I am still suffering. I am trying to do the best to give my child a fair start in life and to raise her to the best of my abilities and hope that she does not develop any mental disorders or anything from the fact that I used drugs. It is not anything that I am proud of. I am quite ashamed of it, but it did happen, and I just would like to see more people help others that were like me because I had no where to go and no one to turn to.

Like I said before, you know, I was not illiterate or anything. I knew better, but I did it. Crack is a very, very strong and very powerful drug. I mean, right up until my baby was born, she had traces of it. I used it and it sent me into labor and HRS kept my child and one of the stipulations was that I receive some intensive treatment through drug agencies, and they referred me to BARC, and BARC has really helped me and they are still helping me right now, you know.

I have a job now working for a reputable company. I love my child. I attend my meetings. Even when I am not scheduled to go, I just stop by. They are always there for me. They help me, and I am just grateful that the turning point in my life was when they took my child and that is the first child that I had and I wanted my baby.

So, I decided that I had to either want to live or want to die, and that is the only thing you can come to on crack, is that of death and destruction.

The CHAIRMAN. Thank you.

Very moving and courageous testimony.

Tom, I by-passed you. Why do you not lead off with the panel here?

Mr. LEWIS. No, I do not have any questions for this witness, Mr. Chairman.

I just want to tell Sarah I appreciate her courage in coming before the panel, and I think that by coming forward, you are helping many, many people right now.

Ms. SARAH. Thank you.

The CHAIRMAN. Clay Shaw.

Mr. SHAW. Sarah, it is a daughter, right?

Ms. SARAH. Yes, sir.

Mr. SHAW. How premature was she?

Ms. SARAH. I was overdue.

Mr. SHAW. You went to term?

Ms. SARAH. I went two weeks past my pregnancy.

Mr. SHAW. And how old is she now?

Ms. SARAH. She is approaching six months.

Mr. SHAW. What is her condition? Have you seen any problems?

Ms. SARAH. No, and she gets—she goes to the doctors at the clinic more than a normal child would go because she is what they call high risk, and they, you know, they evaluate and monitor her, scrutinize closely. They follow, you know, follow her development and growth patterns very closely.

Mr. SHAW. And you did not get off of cocaine until after her birth, is that correct?

Ms. SARAH. Well, using is using whether you slow down or not, but I still was using. Yes, I was. But I have been clean since her birth. Thank God for that.

Mr. SHAW. Thank God every day.

Ms. SARAH. Yes. Every day.

Mr. SHAW. Thank you.

The CHAIRMAN. Ben Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

What is it, Sarah, you think we could do to convince other prospective mothers to avoid this same problem?

Ms. SARAH. Well, like listening to the panels, educate the community, educate the people, you know. Provide more facilities because when I tried to obtain help in my fourth or fifth month of pregnancy, I was turned down. They did not have the bed space, you know. They did not have the facilities. I had to be put on a waiting list.

Mr. GILMAN. Where did you go for help, Sarah?

Ms. SARAH. I got on the phone in a phone booth and I called like all the drug agencies or the social services right down to the Red Cross.

Mr. GILMAN. No one was able to help you?

Ms. SARAH. Except for BARC, and theirs was only out-patient treatment. I needed help like within a facility, you know. Out-patient would not conquer the problem.

Mr. GILMAN. You called the county agencies and local city——

Ms. SARAH. Yes. The intake officer was not in or, you know, I would have to make an appointment or come back later, and I cannot remember now exactly what was said, but, in short, they just did not have the bed space, you know.

Mr. GILMAN. But the out-patient service was able to be of help to you?

Ms. SARAH. Yes. But I did not take it at that time. After I was referred by the social service people here at Broward General. One reason I had not sought their help before was because of the rumors or the myths that go around about these agencies and people, well, you know, it is against the law to use crack and, you know, they are going to put you under arrest and you are going to have a charge for child abuse. Those are the things that will keep people from going. They are afraid, you know. I was afraid.

Mr. GILMAN. Did anyone charge you with anything?

Ms. SARAH. No.

Mr. GILMAN. Charge you with child abuse?

Ms. SARAH. No, not at all. They helped me.

Mr. GILMAN. When you first went to the agency, it was after your child was born, is that correct?

Ms. SARAH. Yes, sir.

Mr. GILMAN. How long after your child was born?

Ms. SARAH. Immediately.

Mr. GILMAN. And that is because you were threatened with the loss of your child?

Ms. SARAH. Yes, sir. I am sorry that it took that, but, you know, that is what happened.

Mr. GILMAN. Thank you for coming forward, Sarah.

The CHAIRMAN. How were you able to find out about the services of BARC?

Ms. SARAH. How I was able? Through the Broward General Social Services people, Director, the one that interviewed me, because after they found traces of the drug in my baby's system, they informed me that my child would not be leaving the hospital and that I would have to come down and talk to someone and they interviewed me, and I was very honest with them.

In fact, when I was admitted into delivery, they asked me the question, do you use drugs, and do you drink or smoke, and I an-

swered them yes, you know, and they looked down on me and scolded me. You know, I just did not realize what I was doing.

The CHAIRMAN. You have shattered some of the myths that people do not know what they are doing when they take crack, but you said you had a loving family and education, some training and background in health care, and still you fell victim.

Was it peer pressure? Was it people——

Ms. SARAH. Yes. The community. The environment.

The CHAIRMAN. And the traffickers. It was access. I mean, they were right there in the streets?

Ms. SARAH. Yes, and where I live, it is still right there. I mean, it is literally at your door step. You do not have to walk——

The CHAIRMAN. You can see the transactions taking place right in the open?

Ms. SARAH. Yes, yes.

Mr. GILMAN. You live in Northwest Fort Lauderdale?

Ms. SARAH. Yes. And I am temporarily—I am living with my relatives. BARC is in the process of helping me obtain permanent residence, but, I mean, you know, I——

The CHAIRMAN. Well, it is good of you to share your experiences with us and your rehabilitation and to laud BARC and Ms. Carter's group for what they are doing, and the fact that you had mentioned your minister giving you strong moral assistance, which is very important that the church gets involved in this struggle as well, and I hope that you can encourage other people that have fallen victim to try to volunteer some of their time so that they would not have to go through the pain that you went through.

Mr. GILMAN. Just one question, Mr. Chairman.

The CHAIRMAN. Mr. Gilman.

Mr. GILMAN. Sarah, how much did your drug habit cost you weekly?

Ms. SARAH. Weekly? Every time I could get scrape up, you know, I did not have an income, and if I got money for food, I went for crack. If I got money for clothing or housing, I went and bought crack. It is just, you know, you want it, you want it.

Mr. GILMAN. Roughly, what did you spend a week on it?

Ms. SARAH. Well, anywhere from—if I could obtain two or three hundred, I would spend two or three hundred. Fifty, I would spend fifty. You know, if I was able to get a million, I probably would have spent a million. I mean, it is just that intense. You do not care about anything. You have to get that feeling, that feeling of euphoria, that crack gives you and it only lasts a few seconds, and the more you smoke, the more you want to smoke because you become immune to that one and you want two and you want three, four.

Mr. GILMAN. So, literally, you spent all your income or whatever money you were given on cocaine?

Ms. SARAH. Yes, yes.

Mr. GILMAN. Thank you.

Mr. SHAW. What church do you belong to?

Ms. SARAH. I belong to the Triumph Church in the Kingdom of God and Christ.

Mr. SHAW. Do they have an outreach program or anything or did you seek——

Ms. SARAH. No. It is a very small church. My relatives were pioneers in the church, but my pastors, they go out and they preach out right in the streets, you know, and they preach—they go like to Skid Row and different places and they try—if there is only just one person that will listen, they are happy that that one person stopped to listen.

Mr. SHAW. You went and sought them out after when you were seeing the possibility of losing your child?

Ms. SARAH. Well, not immediately. After I had decided to turn my life around, I just felt like, you know,—I mean, I had to make my mind up first that I wanted to stop because, you know, there was no fooling just because Broward General referred me.

A lot of girls, they say, well, I am going to go just so I can get my baby, you know, but they are still using the drugs, but I needed that religion in my life because I was raised in the church and I am very grateful to God, very grateful, as well as other people have helped me, you know, including BARC.

It is a very strong thing that you have to fight against and you cannot do it alone, you know, and no matter what agency that you are referred to or that you get help, you have to make up your mind that you want to stop and just say no. Just like the slogan, "Say No To Drugs". You have to say no.

The CHAIRMAN. Thank you so much, Sarah. You are a very courageous lady.

Ms. SARAH. Thank you.

The CHAIRMAN. Mr. Shaw.

Mr. SHAW. Mr. Chairman, this will be our third and final panel. We have Dr., you are going to have to excuse me if I mispronounce some of these names, Dr. Harry Haverkos, Chief, Clinical Medicine Branch, Division of Clinical Research, National Institute on Drug Abuse. Dr. Joseph H. Deatsch, Chairman of the Committee on Substance Abuse of the Florida Medical Association. Dr. Robert J. Sokol, Fellow of American College of Obstetricians and Gynecologists, and Cora Braynon, Registered Nurse, Chairman of the Health Professionals Advisory Committee, Member of the Board of the Broward Division of the South Florida Chapter of the March of Dimes.

Dr. Deatsch, I have been told that you have a plane to catch. I have seen you sit here all morning, and if you would like to proceed first, and then we will go back to the order.

TESTIMONY OF JOSEPH H. DEATSCH, M.D., CHAIRMAN, COMMITTEE ON SUBSTANCE ABUSE, FLORIDA MEDICAL ASSOCIATION, INC.

Dr. DEATSCH. Thank you. Thank you, Mr. Chairman, and members of the committee.

I am here today representing Florida Medical Association. I chair their Committee on Substance Abuse.

I have prepared a written document for the committee which you have, and I am going to push that document aside because of the time constraints that we have. I am very impressed with what has transpired here today. I have been here through the entire hearing.

I think primarily I was aware of the letter that you had written to the Florida Medical Association, Mr. Chairman, and you had asked that we respond to certain specific areas, and I did that in the document that was written.

I am just going to highlight three or four items that I would like to mention and then maybe make a couple of comments.

One thing that our committee—the Florida Medical Association has been very pro-active with drug abuse problems for a long time. Our Committee on Substance Abuse was first started in 1970 as a multi-agency public service committee, and by the late seventies, I was not on the committee at that time, but by the late seventies, it is now a permanent committee and part of our Council on Medical Services.

One highlight that I would like to point out that might seem a little aberrant with some of the problems we have heard about in the State of Florida, that in this past year, the Florida Bar Association and the Florida Medical Association have joined together with a program, a public service program, putting together speakers, panels, of a physician and an attorney to be available to go into communities and respond and addressing the issue of drug abuse, and, of course, crack cocaine.

That amounted to quite a bit of money, about $50,000 from the Bar Association, and $50,000 from the Medical Association, and that is a lot of bucks. Some of that has gone into public service announcements that I hope are still in the process because I would like to go back to Jacksonville and see that some of these public service announcements are certainly keyed to and earmarked for crack cocaine and cover the areas that we have been discussing here today.

We also have had in this past year a Florida Medical Association-sponsored billboard campaign where the FMA advanced $10,000 for each medical society, county society, to match that money for billboards throughout the county on the "Just Say No" anti-drug campaign. There were eleven counties that picked up on that, and we felt that that was a very successful effort.

Another project that has not been mentioned yet here today was the fact that the State of Florida in 1985, because of our cocaine problems, which had already emerged, formed a Florida State Cocaine Task Force. The Florida Medical Association was instrumental in working with Dr. Ron Catanzaro of Palm Beach County, Palm Beach Institute, a stalwart in addiction treatment, long-term member of our association, and Mr. Frank Nelson from our Drug Abuse Department, HRS, Tallahassee.

That was a very active task force, with membership from the National Institute of Drug Abuse, membership from our region, also all the state agencies, law enforcement, and professional agencies. It was a very active task force. We did a lot of investigative work, and about nine months ago, published a report which is in your packet and also a copy is available on the side table, entitled "Crisis in the Land".

It was awfully hard to get that publication ready because new data kept coming in, and we were a little fearful that we were not ready yet and we finally had to cut it and go ahead and send it to publication. I think you will find it a very good reference.

Also in this past year, we have been aware that we need to stay very much on top of physicians, educating physicians, about the drug abuse problem. We have made several efforts in that area, and one project we have accomplished in this past year was to barnstorm our committee in about four different sessions. The putting together of what we call a Physician's Cocaine Handbook. We wanted it concise enough that physicians would use it and we have that available now in your packet. That is one of the attachments, and it is in its pre-printed draft. It is ready to go to press, and we hope to have that distributed to physicians, all physicians, whether they are members of the association or not, within about six weeks.

Also, one major item that I felt was important that the committee wanted to know is if we felt, the Medical Association, that there really is enough literature available to physicians to educate them, and as a result, we requested that the American Medical Association do a survey for us on recent cocaine-related articles, and within a very short time, short hours, we had a print-out of a good many recent medical documents from the literature on cocaine. Also, within the State of Florida in our Medical Library at Jacksonville, we did the same thing and got a print-out of twenty-eight recent articles that are available to Florida physicians in any medical library.

Generally, the articles are from periodicals that physicians receive anyway, and I was impressed that the date on many of those articles were 1987.

One of our projects that we are presently working on, I have just spoken to my colleague here, a physician from N.I.D.A.. I have talked with Dr. Shuster last week in Charleston. We have been working with Dr. Dorynne Czechowicz of the Institute this past year. N.I.D.A. has money. It is not a matter that Washington has not made funds available in a lot of areas, and there are funds available for education programs.

And we have set up in the last five months what we refer to as a trial letter to N.I.D.A. to start the process of grant proposals for physician's education on drug abuse issues with the highlight on cocaine.

Mr. GILMAN. Is that a national problem, Doctor?

Dr. DEATSCH. A national problem?

Mr. GILMAN. A lack of professional education of drug abuse?

Dr. DEATSCH. I perceive it as a national challenge, and it is a matter of how you want to consider the problem.

Mr. GILMAN. Is there a lack of education amongst the doctors with regard to drug abuse?

Dr. DEATSCH. The education sources are there, Mr. Gilman, and they are fairly frequent.

Mr. GILMAN. Part of the curricula?

Dr. DEATSCH. As far as the medical schools are concerned, I have addressed that issue in my written documents, and it is a challenge when you approach medical schools. I did that during the past year. I contacted our three medical schools to ask them what they had in their curriculums regarding substance abuse.

I got a verbal report back from Dr. Don Smith, who is Dean of the Medical School, University of South Florida in Tampa, he is one of our committee members, and I knew about what he was

going to say, and I had a written report from Dr. Diehl, who is the Dean of Medical School, University of Florida. His letter is attached to my report.

Basically, what I hear when I talk to medical schools, Deans or their curriculum committees, is that we have so many hours on substance abuse in these certain years. At the University of Florida, there are about six hours of formal substance abuse education.

Then, I hear, which I think is probably true, that addiction and substance abuse problems are threaded through the rest of our curriculum. I believe there is some validity to that as visible that these are problems that we have, and starting off, of course, with the effects of alcohol, pathology, that we find is spread over other drugs of abuse, would be threaded through.

But I do not know how many threads are there. There is not a very good way to trace that out.

The third thing you hear from the medical schools is, Doctor, we would like to do this, but sit with me and show me, tell me what we should delete from our curriculum if we are going to put something else in.

I believe part of the answer to that, Mr. Gilman, is what they cannot do in the medical school itself should be picked up in the resident programs.

Mr. GILMAN. Well, Doctor, you are telling us there is very little being done——

Dr. DEATSCH. I do not think there is as much being done—I know there is not as much being done as I would like to see done.

Mr. GILMAN. Thank you.

[Statement of Dr. Deatsch appears on p. 135.]

The CHAIRMAN. Tom.

Mr. LEWIS. Well, Doctor, in your testimony, on page 9, you point out that the problem is equal in both the medical school and the residency program. I am concerned that we are not going to need the curriculum for doctors, we are just going to have to add the curriculum for undertakers because if we continue killing people off, we will not need the doctors.

It just seems to me it is important enough that it should be included in the medical school curriculum some way or another.

Dr. DEATSCH. Believe me, we gave the effort in this past year to try to get that done. I think also to fill a gap and we see that is not happening, not to meet my expectations, but I believe we can pick up a gap there with our education program, which I am optimistic that we will be able to write an aggressive proposal that the National Institute of Drug Abuse will be able to fund this.

We are going to do it in association with the AMA and the Florida University Medical School in the state, and set up a very comprehensive education program that would be beamed by satellite to either the hospital satellite network or into one of the other satellite networks.

I think that is a viable approach because the videos can be done in modules and made available across the country for further use and can be expanded upon where we see the expansion is needed to fill in gaps in education. Continuing medical education.

Medical schools are not going to take it up, we have to pick it up at the other end.

Mr. LEWIS. Thanks for yielding.

The CHAIRMAN. Mr. Shaw.

Mr. SHAW. I do not have any questions. I understand you knew my father, Dr. Deatsch.

Dr. DEATSCH. Yes, I did, Mr. Shaw. When I was a young man practicing in Miami, he was one of the stalwarts of Dade County Medicine Association.

Mr. SHAW. Thank you.

The CHAIRMAN. Thank you.

Mr. Gilman.

Mr. GILMAN. Thank you.

I am very much interested in your comments with regard to the lack of education, and I think it is something already mentioned to my Chairman while you were talking that it is something that we should be looking into. It would seem to me that it is a critical enough problem that our physicians who are out there in the front line of all of this should be made more aware of it as part of their formal education, the aspects of narcotics problems.

Dr. DEATSCH. Mr. Gilman, if I may make this recommendation or suggestion to the committee, that the Federal Government funds a good many medical schools for research and so forth and that is a very important—you get a handle on it when you do that. If they want their funds for this research project, what are you putting in your curriculum for substances education.

Mr. GILMAN. We have got the leverage and we should use it.

The CHAIRMAN. Well, if the gentleman would yield——

Mr. GILMAN. I would be pleased to yield to the Chairman.

The CHAIRMAN [continuing]. Florida is fortunate to have someone as concerned as you taking up this issue for the Florida Medical Association, and I for one do not believe that Congress should be intruding in the private sector and telling them what they should or should not do, but, rather, through the American Medical Association, through the experts in this field, we would want to be moved to do what is the right thing, and while we will collectively support the request that you are making to NIDA, we would want to know, I would ask staff, you know, what the American Medical Association is doing on a national level.

It is a very strong and powerful political organization, and it seems to me that we would be pleased to hear what direction they would want, even if they had to come down to Jacksonville to get you to tell them what they need.

Dr. DEATSCH. Mr. Chairman, they have already gotten me because we work very closely with the AMA offices, their Office of Drug Abuse, which is a part of the Division of Human Services, Ms. Bonnie Wilford, who is the Interim Director of that division.

She comes to our Florida Medical Association committee meetings at least twice a year, and we are involved, have been, for the last three years of pulling together physicians education programs for to re-educate and educate physicians on prescription drug abuse and prescription writing, protecting your medical practice and knowing how to prescribe properly.

That program has been a major priority for us, and in the past six months, we finally had pulled together and will be giving our first course in Tampa at the University Medical School there on

November 6th, which will meet the needs of the Boards for any physician who is mandated to take a course of that sort and we will be serving all the Southeastern states with that.

It has been a priority project with this education project of physicians on drug abuse that we would like to work through NIDA to be able to pick that up. It took these people doing all that all at the same time.

We look forward to a good year.

Mr. GILMAN. If the gentleman would yield, Dr. Deatsch, it seemed to me when our committee last looked into this, we found that there was an extremely limited number of hours for all pharmacology being taught to physicians. Is that still the situation in medical schools?

Dr. DEATSCH. Mr. Gilman, I cannot answer you when you break it down into pharmacology because maybe I was at fault when I requested information from the medical school deans. My question was what are they doing in the curriculum for substance abuse studies and drug and alcohol abuse. I did not specify pharmacology.

So, I really do not know.

Mr. GILMAN. Well, as I recall, when we examined this a couple of years ago, looking at the valium abuse and some of the other things, the education was being given by the details who were educating physicians in the schools.

Dr. DEATSCH. Well, I tell you, you are right, the physicians learn their prescribing from their peers. They have learned it under pressure in hospital settings during their residencies. If they learn it from detail agencies, I am not aware of that.

This prescription writing education course we have was not designed primarily to meet the needs of rotten prescribers or bad doctors in that respect. We designed it as a management education course. It was approved to meet our legislative risk management concerning medical education unit.

Mr. GILMAN. Essentially to protect the physician?

Dr. DEATSCH. They need to protect themselves in the matter in which they prescribe. They need to protect the patients. If they do not protect their patients, they are going to get sued and it happens.

Mr. GILMAN. As far as you know, that is not being done in the medical schools?

Dr. DEATSCH. As far as prescribing is concerned?

Mr. GILMAN. Yes.

Dr. DEATSCH. They have learned what are acceptable practices in prescribing. They have learned the proper parameters for what might be called over-prescribing or underprescribing. It depends a great deal upon the physician who is teaching, especially in their resident work.

I would like to point out that when it comes to problems with drug diversion and so forth, the physician that under-prescribes is causing sometimes just as great a problem as one who over-prescribes because that patient, if they are not properly prescribed for in pain management, they will seek out another doctor and a third and it teaches them drug treatment behavior. So, they are concerned about that factor.

Mr. GILMAN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Doctor, you are a credit to your profession. You have activated us into getting more involved in making inquiries of the American Medical Association, and we may be helpful to you with NIDA, if you need our help.

My only question is what do you think about methadone treatment as a modality?

Dr. DEATSCH. Well, I guess I am glad you asked me that. I heard comment this morning about the problem of methadone babies and you saw a methadone baby here this morning.

I have made two notes here at the bottom of the page that I thought that I might make comments and not following my own presentation to you today.

One of them was the epidemiology circumstance of the drug problem. Everybody said, as we sit here and talk, we have got an epidemic. We have got an epidemic. What are we doing about it? And my concern is that we are not treating the drug abuse issue as we would other epidemics, as we have done and treated epidemics in the past. We are not following the medical model.

So, within the last very few weeks, the AMA declared drug abuse now as well as alcoholism a disease. Well, that is fine. It is a matter of who is taking what, but it lends even more credibility to the fact that we had better take a look at our drug abuse problem as an epidemic and treat it as such.

I tell physicians, what did you learn about the Broad Street pump, with plague epidemics? What about Typhoid Mary, how would you deal with those infectious processes? And some of them remember it because they are curious about the history of medicine.

When you talk about substance abuse issues, we are trying to do something about interdicting the drug. We are trying to treat people. What people? We are trying to put a few people in jail, not too many, and they do not stay there very long. Treatment is not available to the indigent addict. Reservations. Congress has provided indigent care, earmarked for drug abuse treatment for addicts, and basically that service has not been available, and when I attend physician meetings or when I go to workshops, I go to a lot of them, and I work in a drug abuse treatment program, I am a salaried physician, I know the problems that we face and that my administration faces.

One thing we are not doing, we are not treating the infected sick person, the indigent street addict. Jacksonville is full of them. Every city in the state is full of them. We forget that when you come to Fort Lauderdale, Miami, Orlando, we have got about five major metropolitan areas in Florida, Florida is a rural state. You fly over a lot of ground and a lot of people to get from one metropolitan area to the area. There is crack cocaine in every county, all of them.

I have seen them in my program coming from all across Northeast Florida and South Florida. The person who does not have money for treatment is not getting treated. This is not the way we treat an epidemic. These sick people are the carriers of the disease. They sell the dope. Most of them are dealers.

I do not care. I do care. It does not bother me when they get put in jail. The longer they are kept there the better. I would like to see them get some treatment in jail. There are some dollars for incarceration treatment. There could be more. That may have been a state problem, I believe, but maybe some federal help would help.

Treatment services need to be available for these people. If they are not going to get any better, they are not seeking help. They feel that it is not available to them and they are right. Some programs, I heard panel number two this morning, this young lady finally got into BARC for some treatment. Made phone calls throughout our state to find a treatment program. You are going to hear, well, if we are a funded program, you can get treatment, you can find treatment if you have got the bucks to go private, but in our funded programs, yes, we treat the indigent, but you will have to have a financial assessment and for you to have your intake assessment done, that is a $50 fee that is non-negotiable. That is non-negotiable.

This week, from the Broward County Medical Society, one of the supervisors told me that one of her employees, this is a telephone answering service, was having a crack cocaine problem. It had not impacted on her work yet. The supervisor did not know it, but she phoned me, the girl says that she is in a lot of trouble, cannot save her money, is broke, her household is falling apart, what can I do to help.

I said let me phone you back because in my position, I do not make those decisions alone. I persuaded my administrator what it would be a good idea to let me do, and he has really been pretty good about it. I am to tell that supervisor to tell this young lady for goodness sake to at least bring five dollars with her because they would accept that for her financial evaluation and her assessment, and because she was employed, she was not indigent, she was out of bucks and a compulsive crack user. So, that is what we have done.

The CHAIRMAN. The question of methadone.

Dr. DEATSCH. I evaded it. I did not mean to. What my aim is, Mr. Chairman, we had another drug epidemic in the late sixties to early seventies. Heroin. And it was threatening our country not quite as bad, but by golly, everybody thought so, as bad as this cocaine epidemic. And we contained that epidemic. It did not go away. We did not get for ourselves a drug-free America.

Now, I think we had better—that sounds good, and I support that, but I think that all of us who are in positions to set policy and affect what we do have to be realistic and realize that right now, we need to contain an epidemic. We have needed to contain them in the past to get the best we can out of it.

Methadone was one of the major answers to the heroin epidemic, and I am saying here in Broward County, where I know that in recent years, probably starting about five years ago, methadone was a black book item. It was an abomination for treating addicts.

The National Institute on Drug Abuse, as an agency, still supports methadone maintenance treatment as a viable modality. I support it when it is properly dealt with as a viable modality to contain an epidemic and help individuals become drug-free and

people who are totally against it are not viewing epidemic proportions of trying to deal with the drug abuse problem.

The CHAIRMAN. Dr. Deatsch, I do not know whether you are going to find people totally against it, but when you talk about viable modality as a treatment, I think it is pretty well known that in the major cities, the City of New York, it is really just dispensed without any treatment, without any counseling, and it is done to contain or to reduce the heroin habit, you know. Crime prevention or whatever to get rid of the people.

But we do not hear anything from the medical profession. I mean, what you are saying is it is just one of the different tools to use in order to try to get the person to become drug-free or even if you were talking about maintaining them, which I do not know enough to understand it, but I will not bother that idea.

But you know it is just being given away. It is legalized as an addictive drug and dispensing it with federal dollars.

Dr. DEATSCH. With control.

The CHAIRMAN. No.

Dr. DEATSCH. With—the methadone programs are not controlled?

The CHAIRMAN. Well, you throw a doctor in there, you know, to make it legal, but it is given to anyone who comes in and there is no one asking, you know, how much have you used this week or are you using, are you still using drugs or has there been a reduction in the amount.

I think Dr. Haverkos saw the New York Times article on 25th Street, Park Avenue. It has been there for years. I am surprised they thought the story was newsworthy.

Dr. DEATSCH. Mr. Chairman——

The CHAIRMAN. Or the AMA or the Florida Medical Association be interested in finding out how doctors are giving away these drugs, methadone?

Dr. DEATSCH. I think that the DEA certainly would be interested in it, and the Florida Medical Association is interested in it.

The CHAIRMAN. They have jurisdiction, but, you know, you have got 2,500 DEA agents throughout the world, and that is all the Attorney General would know is that I have got them all looking over methadone, and I will really have a problem, you know. While they are in Burma and Thailand and Mexico and South America, but it seems to me, though, that the doctors that dispense addictive drugs ought to have some medical responsibility.

Dr. SOKOL. I am sorry. I have not been introduced yet. I am Dr. Robert Sokol. Doctors do not give out methadone. That is just not true. It takes a special license only through special clinics. Physicians do not prescribe methadone.

The CHAIRMAN. Scratch out what I am saying. I am talking about special clinics designed to deal with poor heroin addicts that have a doctor on the premises that allows these people to come in and pick up their methadone. So, I did not really mean doctors generally, but, you see, when you have these so-called clinics, I do not know why I am calling it that, but a place that dispenses methadone, you need a doctor there.

So, I really was not talking about them as a profession, but you need a doctor.

Dr. SOKOL. I believe that across the country, all of those need supervision. Not only federally, but by Joint Commission on Hospitals as well. They all have to be licensed and while I am sure there are some problems——

The CHAIRMAN. There is no question that the doctor was right. It is the DEA that gives the license and it is the controlled substance, but——

Dr. SOKOL. At least from the perspective of taking care of pregnant women, there is really very strong evidence, including some that Dr. Milton published this last year, that methadone really does truly help improve pregnancy outcome.

The CHAIRMAN. Okay. Listen, I want to get back to this. Let me sharpen my criticisms so that I do not over-bend.

I am talking about methadone clinics that dispense methadone without any counseling service, no nurses, no doctors, no psychiatrists, no psychologists, no job training, nothing, except Tang and methadone.

Dr. SOKOL. There is nothing wrong——

The CHAIRMAN. And you need a doctor there to do this legally, somebody of the profession has to be there.

Dr. HAVERKOS. Could I address this particular study, which I think you are talking about the study going on at Beth Israel Hospital.

The CHAIRMAN. I have not laid a glove on Beth Israel yet. I am not talking about Beth Israel. I am talking about a warehouse on Park Avenue and 125th Street where there are more patients outside selling drugs and methadone than those that are inside getting "treatment".

Beth Israel. I am meeting with them next week. That is a different problem. But give this to the doctor.

Mr. GILMAN. Mr. Chairman, would the gentleman yield a moment?

Dr. Udell earlier today told us that methadone was——

The CHAIRMAN. No, no, no. Not to that doctor.

Mr. GILMAN [continuing]. Bad for the pregnant woman. You are saying methadone is——

Dr. HAVERKOS. I think Dr. Udell and I would differ on a number of issues, including that one. It may be from a difference of perception or different specialties. There are many things that I would like to comment on.

The CHAIRMAN. Well, you get your thoughts together on how helpful methadone is to pregnancy and we will get back to you because we know what it does to people that are born and it is going to be helpful to the unborn, maybe we can work on that, too. We might use it even with people unaddicted.

Dr. Deatsch, you opened up a whole lot of stuff here, and Tom Lewis has some questions.

Mr. LEWIS. I do not have any questions for Dr. Deatsch. I think that this testimony has been quite good and lengthy, and I also want to hear from the other doctors, particularly Dr. Sokol, on methadone helping pregnancy. I think that is important.

The CHAIRMAN. Do you get to Washington at all, Doctor?

Dr. DEATSCH. Yes, I do.

The CHAIRMAN. Well, I hope you advise us when you are coming and get some recommendations for us. We would like to explore some of the things that you are doing directly and how we can really be helpful, whether we are talking about the AMA or other questions that we do not have the expertise on.

I want to thank you for recommending Dr. Deatsch before this committee, and I am sorry that you have to leave, and I am sorry we delayed you, but next time you come to Washington, let us know ahead of time so we can arrange our schedule.

Dr. DEATSCH. Fine. The AMA is having an informal steering committee meeting in Washington the first week in December. I believe that is drug abuse-oriented. I will be at that meeting. That is pretty quick.

The CHAIRMAN. That is all right for us, and you might send some materials to us either through Clay Shaw or maybe we would like to sit in on some of these meetings and be better educated. You never did answer about methadone, though, did you?

Dr. DEATSCH. No. I am very sorry. I am not ambivalent about methadone treatment, but I like to see how that program, licensed by the state, how it is run, who the physician is, how they handle their intakes, because I have done these, following the state guidelines. I wish we had different rules. We are very strict in the State of Florida.

Have a counseling staff. That is one reason that some of our methadone programs in this state, they are going down, is because the demand is so great to meet the counselors, to see that they get their counseling sessions, we do not have counseling staff to handle that type of a case load.

The CHAIRMAN. Well, if I can get you away from Florida, I may want to take you around some of my clinics in New York City for methadone distribution and ask your professional advice.

Dr. DEATSCH. I am very sorry. I appreciate the opportunity to be here with you. Thank you.

Mr. SHAW. I would like, before Dr. Deatsch leaves, to point out to the committee that the Florida Medical Association, I think, has taken a real leadership role in the area of drug abuse, some areas controversial with drug testing and whatnot, but I know Dr. Perry has been very interested in the subject and they have done a very good job.

Doctor, if you would like to proceed. If you have a written statement, it will be put in the record.

TESTIMONY OF HARRY HAVERKOS, M.D., CHIEF, CLINICAL MEDICINE BRANCH, DIVISION OF CLINICAL RESEARCH, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. HAVERKOS. Thank you. Mr. Chairman, members of the committee, I am Harry Haverkos, Chief of the Clinical Medicine Branch, Division of Clinical Research, National Institute on Drug Abuse (NIDA).

Dr. Schuster regrets that he could not be here today. I am grateful for the opportunity to represent him and participate in this hearing on this tragic phenomenon known as "cocaine babies".

I will read an abridged version of my testimony and focus on NIDA's response to this problem.

In recent years, we have seen a gradual decline in the use of most illicit drugs by young Americans, with one very serious exception. NIDA's 1986 Survey of High School Seniors showed that use of cocaine continued at peak levels. Unfortunately, 17.6% or about one of every six males and 14.7%, one out of every seven females surveyed had used cocaine during the past year, either in powder form or in a form known as crack, a smokable form of the drug.

Cocaine is now used by more high school seniors than any other illicit drug, except marijuana. An especially disturbing fact is that only a third of the students surveyed believe that experimenting with cocaine was dangerous to the user. A survey of attitudes and knowledge about illicit drug use was conducted shortly after the deaths of Len Bias and Don Rogers and showed an increased awareness of cocaine danger.

However, despite all the publicity about cocaine's addictive potential and toxic effects, it continues to be used by large numbers of people. Confirmation of this increase comes from NIDA's DAWN or Drug Abuse Warning Network data collection effort, where a survey of 750 hospital emergency rooms in twenty-seven major metropolitan areas was conducted.

In 1986, the emergency room mentions of cocaine surpassed mentions of alcohol in combination with other drugs for the first time ever. So, clearly, this is a problem and it is on the increase.

In responding to the cocaine problem, NIDA is addressing the complex issues outlined through a number of initiatives. NIDA has launched research initiatives on the role of drug abuse in adolescent pregnancy, particularly among black youth, and on the effects of maternal drug use during pregnancy.

Attention is being given to prevention, pre-natal care, diagnostic measures, and developmental intervention, and, in fact, this week, seven proposals on the effects of maternal cocaine and fetal development are being reviewed.

Several related research studies are currently under consideration at NIDA. One would explore the extent of risk of fetal loss and infant death in children of cocaine-using women. Another would look at the epidemiology of maternal substance abuse and pregnancy.

Under contract with NIDA and the National Institute of Alcohol and Alcohol Abuse, the American College of Obstetrics and Gynecologists, which we will hear from later, will develop curricula aimed at teaching clinicians to recognize and manage drug abuse in their patients.

These will be used in medical schools and for staff training in hospitals and other health care settings.

Mr. GILMAN. Doctor, if I might interrupt, how will you mandate that?

Dr. HAVERKOS. At this point, we are——

Mr. GILMAN. It is going to be just by invitation to the schools to utilize it?

Dr. HAVERKOS. Dr. Dorynne Czechowicz of the Office of Science of our staff is working with ACOG and with other groups, and I do not know how that will be done. We may hear more about that

from our next speaker. But we are actively involved in that process.

With technical assistance and consultation provided by NIDA, The Healthy Mothers-Healthy Babies Coalition has produced educational materials, such as Drugs in Pregnancy, for health professionals and the public. These materials have been distributed widely to public interest and consumer groups as well as to national and professional organizations.

The Institute has conducted state-of-the-art reviews on the relationship of teenage pregnancy and substance abuse, which is believed to contribute to the initiation of sexual activity. Some 30,000 girls under fifteen years of age become pregnant each year. In fact, forty-six percent of all births of unmarried women are to teenage mothers.

As a result of these technical reviews, grant activity has been stimulated in this area as well as on the effects of drug abuse on the pregnant woman and the fetus. NIDA is working with the Health Resources and Services Administration to ensure that drug abuse concerns are considered in the maternal and child health projects, and in this fiscal year, fiscal year 1988, the Department of Health and Human Services has proposed an $85 million program of demonstration grants calling for the development and implementation of case-managed comprehensive pre-natal and infant services for Medicaid-eligible women and their infants.

NIDA's Drug Abuse Information and Referral Line, 1-800-662-HELP, provides callers with referrals to state and local treatment programs. Callers are given extensive information about the health consequences of using drugs both for themselves and for their offspring.

In summary, NIDA shares your concerns about the effects of illicit substances and particularly cocaine on pregnant women and their offspring. There is much work to be done, and we look forward to working with you toward defining, preventing and diminishing the serious problems being discussed today.

Thank you.

[Prepared statement of NIDA appears on p. 165.]

Mr. SHAW. Thank you, Doctor.

We will proceed now to Dr. Sokol, if you would give us your testimony. We have any full statement that you wish to put in the record, we can, and if you could summarize, the committee is supposed to be—is trying to get out of here by 2:30 because they have a window of arrival into the Washington area, which is going to be a problem after that.

TESTIMONY OF ROBERT J. SOKOL, M.D., FELLOW, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. SOKOL. Well, Mr. Shaw, I promise I will not read it. I am a little dyslexic, so I really just have to talk to people.

I am Bob Sokol. I am the Chairman of the Department of OB-GYN up at Wayne State in magnificent downtown Detroit. That is Detroit, but we do not want you to laugh.

I am also Chief of OB-GYN at Hutsell Hospital. That is something around the tenth largest OB service in the country, and I can

tell you that in Detroit, as here in Florida, we certainly have a major problem with drug abuse during pregnancy.

I have been involved as a scientist in this area for well over a decade. I have had grants from NIDA and NIAAA and I am still very involved as a scientist, and I also run a large clinical service including one of the oldest methadone services in the country, specifically designed for pregnant women.

I am here representing, and I really pleased to have been invited to represent, the American College of Obstetricians and Gynecologists. There is something over 26,000 OB-GYNs in the country, and there is a great deal—our organization and obstetricians and gynecologists certainly have a great deal of concern.

I think the way I got invited is it happened that I chaired the Steering Committee for NIDA/NIAAA contract, the job of which was to look at the education, the kind of questions Mr. Gilman has been asking, what is going on educationally, how are we doing and what else needs to be done.

I am going to limit my comments very, very significantly. I am not going to tell you it is a big problem. You already know it is a problem. But I would like to provide—I think I have got reasonable credentials. I certainly do not want to attack you and I hope that I will not get attacked either, but I would like to bring some balance, if possible, to some of the things that have been said.

You know, we have been talking about as if every baby exposed to cocaine is born brain damaged with two heads. There is not one paper on neural-behavior development in the entire world literature as of today to clearly document that cocaine exposure pre-natally is associated with neuro-behavior or abnormality beyond the short-term, particularly when you are talking about mental retardation.

Now, we do have some evidence that there is CMS effects. No doubt in the eye——

Mr. GILMAN. If I might interrupt, are there studies that have been done?

Dr. SOKOL. There are studies that are going on, but, no, they are not yet published and we just do not have the evidence, and one of the things that I am going to——

Mr. GILMAN. So, you do not have it because we do not have finished studies, is that correct?

Dr. SOKOL. As you heard, there are some studies that are being funded now, but this, as in most epidemics, is a problem which has come on relatively quickly, and I think that we do need to do some things relatively quickly to help decrease the length of it, but I would expect that, as with other epidemics, while we have an endemic level of cocaine use, that people will figure it out, that it is a bad-news drug, and that it will go down relatively quickly.

We will always have some cocaine, but we will continue to have opiates and valium and alcohol and other drugs as well.

The first thing that I think is very important that I would like to get across is we really truly do need much more information, both in the basic science area, and this is something that really Congress does control and can do something about, and in the psycho-social area. Basic science research and psycho-social research.

If we knew—do you not think that if doctors knew how to prevent this problem, how to impact it positively, we would do it? The information just is not there. We talk about public service announcements. I am not against public service announcements, but there is precious little information to indicate that that is going to be an efficacious way of attacking this problem. We do not think you can cure heart disease that way. I do not know why you think we can cure drug abuse that way.

This is not at ali what I was going to talk about. ACOG is——

Mr. GILMAN. Doctor, what are you recommending?

Dr. SOKOL. I will get to that. Let me give you the recommendations up front, and these, I am speaking, instead of screwing around.

Mr. GILMAN. Good.

Dr. SOKOL. I really do think that Congress can help and I think it is going to take, as I think your Chairman suggested, a joint public and private effort.

The first thing is, guys, we really do not know as much as we need to know here and we need more research, we need increased funding and stimulus for people to go into this area, both on the basic medical research side in terms of the effects of drug abuse on both a mother and the fetus. We need increased funding for psycho-social research.

Now, I know that sounds softer and that is not popular right now, but you heard the woman sit here and say, cocaine is at your door step. You put somebody right back into that type of environment. You know, good luck in getting that patient off cocaine. We really need to know more about that.

I do not think there is any doubt, again I am speaking for the American College, that we need increased educational efforts for the public on the harmful effects of drug abuse, especially during pregnancy. N.I.D.A. and NIAAA, both of our drug and alcohol abuse institutes, have clearinghouses, they do the job. I think that they probably could use some more financial support to get the message out there.

I believe that is at least a low-risk thing to do. It is not going to hurt to make people aware of the problem, despite the fact we do not have good evidence that is absolutely going to help.

I do think that you heard something about drug treatment centers. Now, look, there are drug treatment centers out there, but when you hear that there is not much in the way of drug treatment centers available for pregnancy, I do not know what the hell is going on here in Florida, but I know in Detroit, we have to send women out. We have got a program called COTS, and that is basically what they get. They do not want pregnant women in them. God forbid she should go into labor.

We have no place on my service to really send to try to get some help for drug-dependent women because the programs really do not exist. Now, I cannot prove that they do not exist any place, but I think it would be well worthwhile taking a look because if you are going to do something for the baby, you need to do it pre-natally, for the unborn baby. We do not have the resources. Something else.

Finally, I think, on the private side, we do need increased emphasis, and this goes to Mr. Gilman's comments, from national or-

ganizations, such as ACOG, in physician and nursing education as well because nurses are probably a lot more trainable than doctors. We do not tell anybody that, but it is probably true. In the detection and treatment and prevention of substance abuse.

Now, obstetrician-gynecologists are not addictionologists, and it is very difficult. We believe that the best we are going to be able to do and really make it work in a practical level is to get the information across that it is an important medical problem, that we do need to be able to detect the problem, and that then we need to have these people know what kind of treatment and prevention resources are available in the community, and there are communities——

Mr. GILMAN. How do you propose doing that?

Dr. SOKOL. Well, I can tell you what our panel says. We found that we are doing a hell of a job with the practicing docs. Now, the reason is there must be a market out there. I cannot give you exact figures, but when we looked to see ACOG courses from 1986, eighty percent of everything that was being taught had at least something about substance abuse in there. Why would that be? Because the guys out in practice recognize they have got a lot of people out there putting all kinds of good stuff into their bodies. So, they need to know about it.

We agree with you that we need to be doing a better job both during residency and in medical school, and we have put things—there is a set of recommendations in terms of getting information to the appropriate committees and, this is the key, going to the American Board of Obstetrics and Gynecology, Incorporated, because let me tell you, if you test it, they are the guys that test.

If you test it, it will get plugged. You do not have to force anybody to teach anything. You do not want to get into that biz. That is not really what Congress is going to be good at in general, but I think there are other ways to do it, and I think that the College has at least within OB-GYN come up with a viable plan, an action plan, to help increase emphasis in this area.

We are going to CREOG, which is the Council on Re-Education of Obstetrics and Gynecology, which does in-training examinations, the SITROG exam and the American Board.

So, that is the flavor.

Mr. GILMAN. Can you go to the testing of people when it is not being taught and——

Dr. SOKOL. But it is. You know, I do not think that that is—again, it is a matter of perception. Substance abuse is being taught. We did site visits as a matter of fact. This was funded by N.I.D.A. We went out and looked at representative, six representative medical schools around the country in residency programs and, sure, substance abuse along with many other things is part of medical school curricula and residency curricula, and in some places, there are now addictionology institutes.

I was just up at Brown in Rhode Island two weeks ago. I think progress is being made. I do not think that there is so much resistance, but it is true, and I think what you are responding to Mr. Gilman, is the fact that, you know, pregnant women do not want to tell you that they are using cocaine. They do not want to tell you they are alcoholics. There is denial at the professional level as well.

These are very difficult patients to take care of. They are sometimes thankless. One of the things that New England Journal some years ago labeled them as hateful patients. Very difficult and very difficult to get improvement and it is a tough situation, very difficult problem for physicians to detect and to respond to appropriately.

I cannot resist a recommendation I know that the Federal Government is not going to act on or want to act on, but I do think I need to mention these. I have also sat through the hearings all day. You got into an argument before about decriminalization.

It is not only decriminalization I am worried about; it is criminalization. I believe that the kind of law that was passed here in Florida may be a very, very bad idea. I am an obstetrician. If I cannot get—we have got evidence, as a matter of fact, that is what the methadone does, it draws the patients into pre-natal care. If you keep women—you have got problems with access to pre-natal care, if you keep the women from being able to come in, so you can get your hands on them, so you can help—how are you going to prevent?

Now, if you were a woman and you were addicted to cocaine, and you know you are going to be charged with child abuse or they are going to take your baby away, are you likely to come in, are you likely to seek care? Try it. Yeah, gee, sure, go to jail, take my baby away.

The CHAIRMAN. Have you ever heard of this happening any place?

Dr. SOKOL. Yes, sir.

The CHAIRMAN. In the United States?

Dr. SOKOL. How about California? Yes, sir. And how about in Michigan, my state?

The CHAIRMAN. They come for treatment and are put in jail?

Dr. SOKOL. They tried that. The woman was under criminal charges, and I cannot tell you the case. Yes, sir. It really has happened, and we have heard other people here say that is not likely.

You know, before we do things like that, things, ideas which sound good, I think you have really got to think what it does. We know that a major thing that impacts pregnancy outcome is getting women in for good pre-natal care. If we keep drug abusers out of pre-natal care by decreasing access and building barriers, it is possible that we could worsen outcome.

Now, do I have evidence that it does? You asked before another respondent whether or not there was any evidence that it improved outcome. I would ask the question, we need to know what the impact of those type of laws are. It is like the drunk driving while intoxicated laws. Whether there is any impact, and it would, indeed, be a good place for some studies, because there is not much evidence, for instance, of the DWI laws saving lives.

You need to know so that you can make good intervention. You guys treat society very much like doctors treat patients, and it would be good to know whether at the federal level or the state level what we do has impact, but it is not a foregone conclusion that that is such a great idea.

The CHAIRMAN. Thank you.

Dr. SOKOL. Thank you very much.

[Statement of Dr. Sokol appears on p. 172.]

TESTIMONY OF CORA BRAYNON, R.N., CHAIRMAN, HEALTH PROFESSIONALS ADVISORY COMMITTEE, MEMBER OF THE BOARD, BROWARD DIVISION, SOUTH FLORIDA CHAPTER, MARCH OF DIMES

Ms. BRAYNON. I am Cora Braynon, and I am representing the March of Dimes as Chairman of the Health Professionals Advisory Committee.

I am sorry I am last and have about sixty seconds, but I am going to need at least five minutes.

Basically, I appreciate the opportunity. I will not read the statement as it is printed. You should, if you do not, you have a copy for the record.

The March of Dimes, as you can see, our name is preventing birth defects. We know that cocaine use from out in the nation does increase the possibility of prematurity and prematurity is one of the highest contributing factors in terms of birth defects.

So, we are interested in that. My problem in sitting here, though, with this amount of time is that I am also a thirty-year practicing public health nurse here in Broward County. I wear two hats most of the time, and I do have a problem with a lot of things that have gone on and you do not give me time to be Cora Braynon.

But, anyway, the March of Dimes, to answer the questions that came in from the letter from Chairman Rangel, the answers are no, no, yes, no, no, yes. Yes, we are very involved. The March of Dimes is very much involved in doing public education, we provide literature to the Public Health Departments, we will provide literature to private physicians in terms of the reason of not doing drugs.

We work with parent groups, student groups, all at no expense to the taxpayer, but to our donors. So far, we have not gotten involved with health care professional education. We would like to get involved. On a national level, we are very involved with research as it relates to drug abuse.

Are we—this is—but, anyway, the answers are yes, yes and no. So, look at your questions. We do have a video that is about two minutes. We would like for you to see and I sure would like to have some time or write you all a letter and tell you how I feel about taking—making a criminal prosecution of women because they use drugs during pregnancy. It is an illness, not a crime.

Would you go with the video? It is about ninety seconds.

Mr. GILMAN. We will be pleased to accept your letter if you would extend it to the committee.

Ms. BRAYNON. Okay.

[Statement of Ms. Braynon appears on p. 181.]

Mr. GILMAN. Ms. Braynon, we also want to compliment your organization for the pamphlet you put out.

Ms. BRAYNON. Those of you who watch the television stations in the Washington area should know that the Healthy Mothers-Healthy Babies is part of this.

[Whereupon, a video tape was shown.]

Mr. GILMAN. Good, good, good.

Mr. Chairman, before I have to go out and make a telephone call, Dr. Haverkos, you mentioned the emergency telephone line, a hot line. I had our staff call while the panel was here. They called five times and in five incidences, the line has been busy. I hope that there is better response than the response we got today.

The CHAIRMAN. Dr. Haverkos, NIDA keeps talking about a gradual decline in the use of most illicit drugs by young Americans. What do you base that statement on?

Dr. HAVERKOS. That is based on a survey of high school seniors which is done——

The CHAIRMAN. What year was that done?

Dr. HAVERKOS. The most recent one was done in 1986. They compare the statistics with the high school seniors from the year before and the year before that, and——

The CHAIRMAN. Is this the same study that does not take into consideration those who dropped out of school?

Dr. HAVERKOS. Drop-outs would not be in a high school senior survey. That is correct.

The CHAIRMAN. It seems so unfair to do that, you know.

Dr. HAVERKOS. Well, that is the way the study has been set up, to measure, the baseline at the time.

The CHAIRMAN. But that is not—you know, there is no—NIDA was on Mars or something. You know, I get young people in my district and they are not in school and some of them never finish school and then for you to say recent years, we have seen a decline in the use of most illicit drugs by young Americans——

Dr. HAVERKOS. Well, this is one survey of many surveys.

The CHAIRMAN. Where is all of the heroin going and the marijuana? Where is it going? There has been increases in production. They do not bring it over and flush it down the toilet. So, I read that there has been a gradual decline, you know, forget cocaine and crack, and I am so elated, and I want to know. Why the hell is it that the DEA says that there is more coming in than ever before?

Dr. HAVERKOS. You are talking generally about a cohort effect and the people that have graduated from high school or have not finished high school, but were eighteen in the sixties and seventies, are one of the cohort effect going through.

Now, those people are not picked up in a high school senior survey.

The CHAIRMAN. You do not say high school senior survey in your—you never do. NIDA never does.

Dr. HAVERKOS. I thought I said——

The CHAIRMAN. I am talking about Dr. Schuster.

Dr. HAVERKOS. There is another problem with the high school senior survey. It depends on——

The CHAIRMAN. We are not talking—you do not talk about high school senior surveys when you make these remarks.

Dr. HAVERKOS. The second sentence, "NIDA's 1986 Survey of High School Seniors showed . . .".

The CHAIRMAN. Well, the first sentence says, "Recent years have seen a gradual decline in use of most illicit drugs by young Americans with one serious exception."

Dr. HAVERKOS. That is based on the——

The CHAIRMAN. High school senior survey.

Dr. HAVERKOS. Also, there is also a national household survey, which is another survey that we look at, and that again goes randomly throughout the country in households. Obviously, it does not——

The CHAIRMAN. Are we saying that there is less consumption of marijuana and heroin by younger Americans? Is that what this is going to end up with saying?

Dr. HAVERKOS. That is not what we are saying. What it is saying is that in people that are now seventeen years old or twelve to seventeen years in the household survey, compared to people that were twelve to seventeen last year or the year before, that the proportion reporting use of these drugs is less than it was from one year to the next. In other words, it is a recruitment, a recruitment of new drug users. I mean, it is one positive sign.

Now, whether it is one of——

The CHAIRMAN. I do not know. If they are ending up in the emergency ward using heroin, methadone, cocaine and alcohol, then I read that—but, still, you know, there is a decline and we have increases in overdose, I do not understand it.

Dr. HAVERKOS. Again——

The CHAIRMAN. And an increase in production, an increase in interdiction, an increase of the amount that is on the streets, you know, then you get this from the police department, DEA, and you get from the doctors in the emergency wards, and then you read that there is a decline, a gradual decline in use.

Dr. HAVERKOS. It comes down to what you emphasize from your data. But if you look at the older age groups, you are right, and that is where you are picking up. If you look at the results from the DAWN survey, individuals who come in to the emergency room with cocaine overdoses, predominantly it is people between twenty and thirty-five.

The CHAIRMAN. So, you are saying that older people will use more and older people are now being turned on heroin more? The older they get, the——

Dr. HAVERKOS. The people that went through that are older and they may have started when they were sixteen or seventeen.

The CHAIRMAN. And now their habits have increased, so they are increasing their consumption when they get older.

Dr. HAVERKOS. Now, for example, if they are thirty-one and they are not going to be picked up in a high school senior survey, and we compare the proportions of sixteen and seventeen year olds using heroin and other drugs to 16 and 17 year olds ten years ago. Actually, the curve goes up——

The CHAIRMAN. Okay. I will take any good news no matter how you get it. It is just that I am going to have to explain this to somebody and I find it very difficult to do, but maybe you can spend a little more time with me and we can work this out.

Dr. HAVERKOS. I would be happy to do that.

The CHAIRMAN. And you were saying, Dr. Sokol, that it is your experience that methadone is helpful to pregnant mothers, right?

Dr. SOKOL. One of the ways it can be helpful is that mothers on methadone continue very often, continue to use other drugs. They may user fewer other drugs, smaller doses of other drugs, and we

believe, at least I believe, and I am speaking for myself, not for the American College, we interpreted our results to indicate we had significantly fewer dead babies, significantly fewer babies who have fetal distress in women who were complying came in and were on the methadone program.

Also, they were part of our high-risk clinic, and who got very intensive nursing, social and medical care throughout their pregnancies, and what the methadone really did for us was to act as a hook, if you will, to help draw them in to pre-natal care.

At least in Detroit, it is the only such program in Detroit. We deliver around a third of the women of all women who deliver a baby in Detroit. This was an effective way of helping take care of these patients. It is not ideal. I do not want to say that.

The CHAIRMAN. So, it is a piece of candy. This is a sweetener to get them into health care.

Dr. SOKOL. The best evidence is that methadone acts like other opiates and undoubtedly is not as good for pregnancy, is not being exposed to any illicit substance at all, compared with using stuff from the street, where you really do not know what you are getting, and it is often mixed with other things. We believe that on balance, it is a positive contribution.

The CHAIRMAN. Well, if you are getting good stuff off of the street and good methadone, which would be the most addictive?

Dr. SOKOL. It is not a matter of addictive. In terms of infant outcome——

The CHAIRMAN. Maybe I am using the wrong term.

Dr. SOKOL. In terms of infant outcome, it may be—heroin may be a little bit less of a problem with a slightly shorter withdrawal period than methadone. You are comparing bad and perhaps not so bad.

This is one of the areas and one of the reasons that I suggested we need more psycho-social research. There is so many other things contributing other than the pharmacology of the drugs, lifestyle issues, that are a disaster in terms of infant outcome, that it is just——

The CHAIRMAN. What are you agreeing to, Ms. Braynon? I see your head shaking yes, but I do not know what you are agreeing to because what he is saying is that, you know, it is all bad, one is worse than the other.

Ms. BRAYNON. The drug use is coupled with a number of other lifestyle problems. The prostitution, the no eating, the no housing. The pregnancy, in our experience, has been a result—is really an accident of them earning money to get the drugs. I mean, they did not go out with the intent of getting pregnant. They went out with the intent of earning money and they happened to get pregnant.

So, their lifestyle is one that is not conducive——

The CHAIRMAN. But tying that into giving methadone after they are pregnant, giving them methadone.

Ms. BRAYNON. Okay. My concern is that if they are under an adequate—a treatment system of some kind, it is better than them being out in the streets.

The CHAIRMAN. No one is arguing with that. I am just saying, tell me how methadone helps.

Dr. SOKOL. Methadone saves babies' lives.

The CHAIRMAN. That is what we are talking about.

Dr. SOKOL. If the baby withdraws in utero, in other words, if the mom does not get her drug, if a baby withdraws, there is a high rate of still birth. That can be avoided by keeping women on methadone.

The CHAIRMAN. Then you would also have to say that it would be even better medical practice if we gave the mother heroin while she was pregnant.

Dr. SOKOL. That is done in Britain.

The CHAIRMAN. No, no, no. I am asking a question.

Dr. SOKOL. No, that is done. Heroin——

The CHAIRMAN. No, no, Doctor, please.

Dr. SOKOL. Heroin would be——

The CHAIRMAN. I am asking that hypothetical question, that if you believe that methadone could be helpful to the child and to the mother in pregnancy, then you would also have to believe that it would be even better to give the mother heroin.

Dr. SOKOL. I think that the answer to that is that the receptor for opiates does not know the difference between methadone and heroin. From the standpoint of the baby and preserving a baby's life in utero, it is irrelevant.

The CHAIRMAN. I thought you said that it was your professional opinion that there was a shorter period of withdrawal from heroin than there was from methadone.

Dr. SOKOL. Yes, that is true, but when she is buying it on the street——

The CHAIRMAN. No, no, we are not talking about purchases, Doctor. I am asking you, because I do not know and if I have to legislate and I want to help pregnant mothers and someone says give them methadone——

Dr. SOKOL. Well, what you should say——

The CHAIRMAN [continuing]. I would say, Dr. Sokol would prefer to give them heroin.

Dr. SOKOL. Yeah, but I am not going to let you do that because what you want me to do is to end up representing the American College on television saying that I think heroin is a good idea.

The CHAIRMAN. No, no. We will strike any radical statement that you would make, Doctor, from the Medical College and just ask you your personal radical opinion.

Dr. SOKOL. If you really want to know the answer, I would have had an opportunity to speak.

Mr. SHAW. Mr. Chairman, I believe—I think the record is starting, to muddy it up a little more, it is starting to get a little clearer. I think Dr. Udell this morning told us that he thought that the—in his experience, that the withdrawal from methadone was worse than heroin. I believe that is what he said. He is still here.

Dr. SOKOL. I would agree with that.

Mr. SHAW. I believe he is indicating that by shaking his head. But they have both got to be total disasters.

Dr. SOKOL. It would be better if the woman did not need to be on either from the fetal perspective. I am responsible as a peronatologist for the baby prior to birth. You are surely better off in an addicted baby and an addicted mother and fetus to have an even level of drug without in utero withdrawal.

We do not have evidence like that for cocaine. There is strong evidence of that for opiates. Indeed, heroin has been used in that way and is of a continuing use with similar results to what we have in this country.

The CHAIRMAN. Doctor, we have been to England and we have had parliamentarians as well as doctors come here and share the England experience with us, and they say that the heroin experiment is a total disaster, and that they are now moving to methadone.

I am not saying that with pregnant women that they are not still using it, but I am talking about as a maintenance or as a treatment modality, they are trying to learn from us and you know how deep their problem must be if they are doing that.

Dr. SOKOL. Oh, we certainly try to learn from each other.

The CHAIRMAN. Thank you so much.

Dr. SOKOL. Thank you.

The CHAIRMAN. Thank you for your testimony, and thank you, Clay Shaw, for bringing us here.

Mr. SHAW. Thank you, Mr. Chairman.

I would also like to thank all the witnesses and Broward General Hospital who has been a wonderful host for us and for opening up the neo-natal unit and providing this hall and all the wonderful facilities.

The CHAIRMAN. Thank you again, Dr. Udell.

[Whereupon, at 2:45 p.m., the committee was adjourned.]

[The following statements were supplied for the record:]

OPENING STATEMENT

OF

THE HONORABLE CHARLES B. RANGEL

CHAIRMAN OF

THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

FOR HEARING ON

COCAINE BABIES

AT

BROWARD GENERAL MEDICAL CENTER

FT. LAUDERDALE, FLORIDA

FOR RELEASE:

FRIDAY, OCTOBER 16, 1987

GOOD MORNING. DURING MY TENURE AS A MEMBER AND AS CHAIRMAN OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, WE HAVE DEALT WITH A NUMBER OF VERY DIFFICULT AND PERPLEXING ISSUES. THE SUBJECT OF OUR HEARING TODAY, THE EFFECT OF MATERNAL COCAINE USE ON NEWBORNS, IS ONE OF THE MOST DISTURBING WE HAVE CONFRONTED.

SEEING THOSE BABIES IN THE PEDIATRICS WARD THIS MORNING WAS SIMPLY HEARTBREAKING. THEY ARE SO TINY AND THEY HAVE SUFFERED SO MUCH IN THEIR SHORT LIVES. THEY ARE TRULY THE INNOCENT VICTIMS OF THE COCAINE EPIDEMIC SWEEPING OUR NATION. AND, AS A FATHER AND A LEGISLATOR, I AM AFRAID FOR THEIR FUTURES.

WE WILL HEAR FROM A DISTINGUISHED LIST OF WITNESSES TODAY. THEY WILL TELL US ABOUT THE PROBLEMS EXPERIENCED BY THESE BABIES, THE EFFORTS BEING UNDERTAKEN TO ADDRESS THEIR SPECIAL NEEDS, AND THE PROGRAMS AND ACTIVITIES DIRECTED TOWARD PREVENTING MORE INFANTS AND CHILDREN FROM BECOMING THE VICTIMS OF COCAINE.

I WANT TO THANK, MY COLLEAGUE, REPRESENTATIVE CLAY SHAW FOR BRINGING THIS PROBLEM TO THE ATTENTION OF THE SELECT COMMITTEE AND INVITING US TO HOLD THIS HEARING IN HIS DISTRICT. I ALSO WANT TO THANK THE STAFF OF BROWARD

GENERAL MEDICAL CENTER FOR THEIR ASSISTANCE AND HOSPITALITY. AND, I WANT TO THANK THE MEMBERS OF THE SELECT COMMITTEE WHO ARE WITH US TODAY.

DURING THE PAST DECADE, THERE HAS BEEN AN UPSURGE IN COCAINE USE NATIONWIDE, CROSSING ETHNIC, RACIAL, AND SOCIOECONOMIC LINES. TRAGICALLY, COCAINE'S POPULARITY HAS GROWN BECAUSE OF THE INCREASED AVAILABILITY AND PURITY OF THE DRUG, LOWER PRICES, THE ADVENT OF "CRACK", A FREEBASE FORM OF COCAINE THAT CAN BE SMOKED, AND THE CONTINUED MISPERCEPTION THAT COCAINE IS A SO-CALLED "SOFT DRUG" THAT CAN BE USED WITHOUT CONSEQUENCE.

TODAY, AN ESTIMATED 25 MILLION AMERICANS HAVE USED COCAINE. FIVE TO SIX MILLION USE IT REGULARLY. AMONG THE REGULAR USERS, APPROXIMATELY TWO MILLION ARE WOMEN. AND, THE NUMBER OF WOMEN USING COCAINE IS EXPECTED TO INCREASE.

MOST WOMEN WHO USE COCAINE ARE IN THEIR CHILD-BEARING YEARS. IT HAS BEEN ESTIMATED THAT AS MANY AS 10 PERCENT OF PREGNANT WOMEN MAY HAVE TRIED COCAINE AT LEAST ONCE DURING THEIR PREGNANCIES.

AS A CONSEQUENCE OF THE INCREASED USE OF COCAINE BY WOMEN, HOSPITALS ARE SEEING A GROWING NUMBER OF INFANTS BORN SUFFERING FROM THE EFFECTS OF MATERNAL COCAINE USE. MANY OF THESE BABIES ARE BORN PREMATURELY. SOME SUFFER FROM WITHDRAWAL-LIKE SYMPTOMS. SOME HAVE EXPERIENCED HEART ATTACKS, STROKES, AND RESPIRATORY PROBLEMS. THERE IS

MOUNTING EVIDENCE THAT THESE CHILDREN ARE MORE VULNERABLE TO SUDDEN INFANT DEATH SYNDROME (SIDS) OR CRIB DEATH. FINALLY, PRELIMINARY REPORTS SUGGEST A VARIETY OF POTENTIAL LONG TERM PROBLEMS SUCH AS MENTAL RETARDATION, HYPERACTIVITY, AND LEARNING DISABILITIES.

TO PREVENT MORE INFANTS FROM BECOMING VICTIMS OF COCAINE ABUSE, OUR FIRST LINE OF DEFENSE MUST BE A COMPREHENSIVE NATIONAL ANTI-DRUG STRATEGY. SADLY, DESPITE CONGRESSIONAL EFFORTS AND THE SIGNING OF THE ANTI-DRUG ABUSE ACT OF 1986 BY THE PRESIDENT, THE WHITE HOUSE STILL HAS NOT IMPLEMENTED SUCH A STRATEGY.

WE ALSO MUST REACH OUT TO PROSPECTIVE MOTHERS. THERE ARE A NUMBER OF EFFORTS THAT NEED TO BE UNDERTAKEN.

FIRST, WE MUST ENSURE THAT ALL THOSE IN NEED OF DRUG ABUSE TREATMENT--MEN, WOMEN, OR CHILDREN--RECEIVE SUCH TREATMENT.

SECOND, WE MUST PROVIDE BROAD-BASED DRUG ABUSE PREVENTION AND EDUCATION IN OUR SCHOOLS AND COMMUNITIES.

THIRD, WE MUST INCREASE OUR EFFORTS TO ENSURE THAT ALL WOMEN WHO ARE PREGNANT, OR ARE IN THEIR CHILD-BEARING YEARS, HAVE ACCESS TO QUALITY PRENATAL CARE. WE CANNOT WAIT FOR THEM TO COME INTO THE EMERGENCY ROOM TO DELIVER THE BABY TO TELL THEM ABOUT THE POTENTIAL DANGERS OF DRUG ABUSE. THAT IS TOO LATE.

FOURTH, TO REACH THE WOMEN, WE MUST REACH THE MEDICAL PROFESSION. WE MUST ENSURE THAT EVERY MEDICAL PROFESSIONAL IS AWARE OF THE SYMPTOMS OF DRUG ABUSE. ASKING QUESTIONS ABOUT DRUG USE AND PROVIDING INFORMATION ON ITS EFFECTS, PARTICULARLY TO PREGNANT WOMEN, MUST BECOME ROUTINE.

WE ALSO MUST RESPOND TO THE NEEDS OF THE CHILDREN WHO ARE ALREADY LIVING WITH THE EFFECTS OF MATERNAL COCAINE ABUSE. SHORT-TERM AND LONG TERM HEALTH CARE, SOCIAL SERVICES, AND SPECIAL SUPPORT SERVICES TO HELP THE MOTHERS OF THESE CHILDREN CARE FOR THEM WILL HAVE TO BE PROVIDED. IN SOME INSTANCES, THESE CHILDREN WILL NEED LONG-TERM SPECIAL SERVICES FOR LEARNING DISABILITIES, RETARDATION, OR BEHAVIORAL PROBLEMS. THESE NEEDS MUST BE MET.

SOME OF THESE CHILDREN WILL NEED FOSTER CARE OR ADOPTION SERVICES. WE MUST ENSURE THAT THESE SERVICES ARE PROVIDED.

FINALLY, THERE ARE A NUMBER OF ISSUES THAT WE, AS POLICYMAKERS, WILL HAVE TO ADDRESS. WHO SHOULD FINANCE THE MEDICAL AND SOCIAL SERVICE CARE OF THESE CHILDREN? SHOULD A CHILD WHO IS THE VICTIM OF MATERNAL DRUG ABUSE BE CONSIDERED ABUSED? WHEN SHOULD THE STATE HAVE THE RIGHT TO INTERVENE IN SUCH CASES?

I AM SURE THAT THESE QUESTIONS AND MANY OTHERS WILL BE EXPLORED TODAY. AND, I HOPE THAT WE WILL COME AWAY WITH ANSWERS TO MANY OF THEM.

STATEMENT OF THE HONORABLE E. CLAY SHAW, JR.
OCTOBER 16, 1987

I WOULD LIKE TO WELCOME YOU, MR. CHAIRMAN AND CO-CHAIRMAN, AND MY FELLOW COLLEAGUES OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL TO FORT LAUDERDALE. YOU SHOULD BE COMMENDED FOR YOUR LEADERSHIP IN CONVENING THIS HEARING AT THE BROWARD GENERAL MEDICAL CENTER TO LEARN ABOUT THE PLIGHT OF COCAINE'S YOUNGEST VICTIMS -- COCAINE BABIES.

HAVING JUST COMPLETED A TOUR OF THE NEONATAL INTENSIVE CARE UNIT, WE HAVE HAD THE OPPORTUNITY TO WITNESS THE NEEDLESS PAIN AND SUFFERING THESE CHILDREN EXPERIENCE IN THEIR FIRST DAYS OF LIFE -- SUFFERING CAUSED BY COCAINE. AS THE NEWEST MANIFESTATION OF OUR NATION'S COCAINE EPIDEMIC, THIS ISSUE CERTAINLY DESERVES THE ATTENTION OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL. I AM AFRAID THAT WE ARE JUST BEGINNING TO REALIZE THE EXTENT OF THIS PROBLEM. WE ARE PRODUCING A NEW GENERATION OF CHILDREN EXPOSED TO THE SCOURGE OF DRUGS FROM THE MOMENT OF BIRTH. THE IMPLICATIONS OF THIS PROBLEM ARE ENORMOUS. LET ME EMPHASIZE THAT THE SUFFERING WE JUST WITNESSED IS A MERE PRELUDE FOR THE HEALTH PROBLEMS AND PERMANENT MENTAL AND PHYSICAL DISABILITIES THAT THESE YOUNGSTERS MAY LIVE WITH ALL THEIR LIVES, IF THEY LIVE, AS A RESULT OF THEIR EXPOSURE TO COCAINE.

I AM LOOKING FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES TODAY. I RECOGNIZE THAT MANY OF YOU HAVE WORKED IN FORT LAUDERDALE AND BROWARD COUNTY TO CRAFT AN INNOVATIVE PROGRAM

SO THAT ALL WOMEN OF CHILDBEARING AGE CAN BE WARNED ABOUT THE DANGERS OF COCAINE ABUSE. WHILE I AM ENCOURAGED BY THE PROGRESS THAT HAS BEEN MADE, CLEARLY, MUCH REMAINS TO BE DONE FOR THE PROTECTION OF THESE INFANTS BOTH HERE IN FORT LAUDERDALE AND IN OTHER AREAS OF OUR NATION.

AS MEMBERS OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, WE HAVE ASSUMED THE TREMENDOUS RESPONSIBILITY OF LEADING OUR NATION IN THE WAR AGAINST DRUGS. I WOULD LIKE TO THANK ALL OF YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS HEARING TODAY.

I INTEND TO CONTINUE TO WORK WITH MY COLLEAGUES ON THIS COMMITTEE TO ENSURE OUR NATION'S MOTHERS AND BABIES ARE HEALTHY AND DRUG-FREE.

OPENING STATEMENT

CONGRESSMAN TOM LEWIS

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL

FIELD HEARING
FORT LAUDERDALE, FLORIDA

October 16, 1987

Good morning, Mr. Chairman, fellow committee members, members of the media and other honored guests.

South Florida's cocaine epidemic has spread to a new generation of victims - newborn children. Sadly, cocaine use is increasing, particularly among women of child-bearing age. Consequently, the disease will undoubtedly continue to spread to more and more of these helpless victims.

Drug-addicted infants typically spend four to six weeks in intensive care at a cost of $28,000. When we add the factors of physical and emotional misery, you can begin to appreciate the horrendous price this disease extracts from the mother, the child and the community at large.

Everyone here has played a role in various efforts to protect our children. But there is still much more that needs to be accomplished. It is my hope that we can walk away from here today with some of the answers we need to put an end to this devastating crime.

STATEMENT OF THE

HONORABLE BENJAMIN GILMAN

RANKING MINORITY MEMBER

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

FIELD HEARING

ON

"COCAINE BABIES"

BROWARD GENERAL MEDICAL CENTER

FORT LAUDERDALE, FLORIDA

Friday, October 16, 1987

THANK YOU, MR. CHAIRMAN.

OUR NARCOTICS SELECT COMMITTEE IS IN FORT LAUDERDALE THIS MORNING TO ASSESS THE SCOPE OF AN ESCALATING SITUATION WHOSE URGENCY WAS BROUGHT TO OUR ATTENTION BY CONGRESSMAN CLAY SHAW, A SENIOR MEMBER OF OUR COMMITTEE. WE ARE GRATEFUL TO HIM FOR THIS, AND HOPE THAT WITH TODAY'S FORUM, CONGRESS WILL HAVE A BETTER UNDERSTANDING OF THE PROBLEM AT HAND AS WELL AS SOME VIABLE RECOMMENDATIONS.

OUR SELECT COMMITTEE HAS FOCUSED ATTENTION ON THE GROWING USE OF CRACK COCAINE, REGRETTABLY ITS ABUSE HAS GROWN. EMERGENCY ROOM VISITS ARE UP, AS ARE COCAINE RELATED DEATHS.

BECAUSE CRACK COCAINE IS SMOKED RATHER THAN SNORTED, AND ITS HIGH MORE INTENSE, IT HAS BECOME VERY POPULAR AMONG ALL SEGMENTS OF OUR SOCIETY. IT NOW APPEARS THAT CRACK COCAINE IS ADDICTING A GREATER NUMBER OF WOMEN. WE ARE WITNESS TO THAT VERY SERIOUS SITUATION IN THIS HOSPITAL.

EARLIER THIS MORNING, DURING A TOUR OF BROWARD GENERAL MEDICAL CENTER WE WERE CONFRONTED BY THE TRAGIC SIGHT OF SEVERAL COCAINE AFFLICTED INFANTS. THEY ARE GENERALLY UNDERWEIGHT AND PREMATURE, AND WE WERE TOLD, SUFFER FROM A HOST OF OTHER SERIOUS COMPLICATIONS.

IT IS BECAUSE MORE AND MORE COCAINE BABIES ARE BEING BORN

THROUGHOUT THIS COUNTRY THAT THE SELECT COMMITTEE ACKNOWLEDGED THE NEED TO TAKE A CLOSER LOOK AT THE PROBLEM. THAT IS WHY WE ARE HERE TODAY IN FORT LAUDERDALE. OUR PANELISTS THIS MORNING ARE FRONTLINE EXPERTS ON THIS ISSUE. I HOPE THAT THEIR TESTIMONY WILL BE ABLE TO INFORM OUR SELECT COMMITTEE EXACTLY HOW THE GREATER FORT LAUDERDALE AREA HAS RESPONDED TO THIS CRISIS, HOW IT IS COPING WITH THIS CRISIS, AND WHAT REMAINS TO BE DONE TO PREVENT AND TO TREAT COCAINE ADDICTED WOMEN AND THEIR BABIES.

IT WOULD ALSO BE APPRECIATED IF OUR WITNESSES WOULD OUTLINE FOR US ANY UNMET NEEDS THAT CAN BE ADDRESSED BY THE FEDERAL GOVERNMENT. IF WE ARE TO EFFECTIVELY COMBAT THIS GROWING THREAT, WE NEED TO RESPOND IN A COMPREHENSIVE, COORDINATED MANNER AT EVERY LEVEL OF GOVERNMENT. FAILURE TO DO OTHERWISE THREATENS THE VERY FABRIC OF OUR NATION'S MOST PRECIOUS RESOURCE -- OUR YOUNGSTERS.

COCAINE ADDICTION IN THE NEONATE

BRIAN D. UDELL, M.D.

Historically, substance abuse during pregnancy, for some reason, has always been something that, once you talked about it; it seemed to go away. I wake up every morning, and I'm sure that I won't have to tald about cocaine any longer. Why would anyone do cocaine during their pregnancy? And it doesn't go away; it gets worse. Grim is the correct word to use, because what's coming out lately, in the last six or eight months, is the association between venereal disease and cocaine addiction, and it is just becoming a major diagnosis in our Neonatal Intensive Care Unit at Broward General Medical Center here in Fort Lauderdale, Florida.

To start, the problem of substance abuse we are at present seeing was born of alcohol abuse, and everbody thought that alcohol abuse would be a big problem. In 1960's, there were many articles published about Fetal Alcohol Syndrome(FAS); and, reviewing all of the literature one would think that there would be more babies with FAS than we normally see, even when we're looking for it. That is, there was a time in the 60's and early 70's when it was said that any amount of alcohol during the pregnancy could cause the baby to have FAS. The syndrome is basically characterized by a certain type of face--a certain look to the baby, and most devastating is mental retardation and abnormal motor development. I try to be very careful when I talk about this; I'm not condoning alcohol during pregnancy, but there has been a recent article, in the New England Journal of Medicine, where an attempt was made to show how much alcohol it took to produce birth defects, because they've been looking for that for years. The results--and, again, this doesn't mean that you should have one drink a week; but, apparently, one drink a week was not significantly associated with the Fetal Alcohol Syndrome.

The point that the authors were trying to make was that any amount of alcohol during pregnancy was bad; however, there are people who are going to have one or two drinks a week, and a woman should not spend the rest of her pregnancy totally despondant and thinking that the baby is going to be malformed because she happened

to have one drink a week. And I think that for the 10,000 years of mankind when alcohol has obviously been around, it just couldn't be that FAS was as easy to produce as they were saying in the 60's and 70's.

At Broward General, of our 6,000 yearly deliveries, we have 23% that are high risk. What we see is that FAS occurs in about one in a thousand babies, but this would be produced more than six times a year in our Medical Center if anything more than an occasional drink caused fetal alcohol syndrome, because I'm sure that more than one in a thousand women have more than one drink a week during their pregnancy. It's just not reasonable to think they don't, especially when you consider that the women don't stop taking the drug that they take, or drinking the alcohol that they do until they find out that they are pregnant, and you don't find out that your're pregnant until alot of gestation has taken place. You don't find out that you are pregnant until the end of the first trimester, usually, when most of the organogenesis has taken place. So, it's not that alcohol is good; it's just that very small amounts of alcohol are probably not that bad.

In the 60's, marijuana started being used more and more, and there was a question about teratogenicity--the effect of marjuana, causing problems in the fetus. And there have been many controversial articles questioning what kind of problems come frome the use of marijuana during pregnancy. The first thing that I'd like to say about marijuana during pregnancy is: If it were only for the smoking effects, you wouldn't want to do the marijuana during the pregnancy because we know the effects of smoke, carbon monoxidae, methane,all the gases that come out of cigarettes, and nicotine and tar--on a fetus. They have effects on the breathing movements of the fetus, and on fetal size. So, forgetting all the studies that are controversial as to whether or not marijuana has effects on the fetus, just take the smoke as having an effect on the fetus and then question whether or not you would want to cause those effects to your infant.

The other question that should come up in a person's mind is that marijuana, whatever it does, affects the central nervous system. If affects the central nervous system in the fetus at a time when the cental nervous system is the most rapidly developing and forming part of the body. So whatever effects it has, that is the chance that a person is taking, and those effects may not come out for years and years. And the warning that I would give people about marijuana is just take it on its face; you don't have to go lookin.g for occassional problems and the smoking itself is harmful.

Most of the drugs that we'll be talking about today are lipid-soluble drugs: they get into fat tissues very easily. Fat tissues are in breast milk; fat tissue is in the brain; and so they get into breast milk and brain really easily. And whether or not somebody says a little bit of a drug is OK, to me it's a moot point, because nobody can know what's OK for a developing mind, and you're taking that chance for the rest of the child's life.

The next drug that came into vogue in the 70's was LSD. And I'd like to talk about LSD for a second, because the day that it was found that LSD causes chromosome damage in some laboratory animals it seemed that it disappeared. Everybody was afraid of their chromosomes breaking, and there was no more LSD around, and I wish cocaine broke chromosomes; because, if it did, I don't think we'd have a cocaine problem. Nobody is afraid of cocaine like they were of LSD, and some policemen in Fort Lauderdale tell me that there is a resurgence, now, of LSD for a couple of reasons. For one, it is very cheap and apparently produces a potent high for a very small amount of money. Secondly, the kids are not aware of the problems that we knew about. I mean, now it's a new generation of people who are not aware of problems associated with LSD in their own bodies, let alone in a fetus's body. LSD got put aside right away, though there could be a resurgence, like I say, and people should be watching out for that.

In another area, in the mid-70's, when they started doing a lot of designer drugs--mixing a whole lot of different drugs and seeing what happens--I guess to find out what euphoria you can get from those drugs. I don't have much to say about those other than that there would be no way to do a controlled study, unless one could find out exactly what these people were abusing.

Next comes methadone and heroin. One thing I always like to say to groups who are going to have any kind of contact with methadone people is that the methadone clinics are wrong, wrong, wrong! Because methadone is bad for babies.

In recent literature, where comparisons of the outcome of babies born to mothers who use heroin or methadone, the methadone babies have a worse outcome. They have a very high chance of convulsions after two weeks when the methadone gets out of their system, and the problem seems to be that their mothers were taking a known dose of the drug throughout pregnancy. Methadone clinics should be encouraging those women to wean themselves off the drug, so that when the kid gets born they won't have

methadone in their system, and they won't have those problems with convulsions. Methadone babies are doing very poorly, neurologically, in followup also. So any methadone clinic that is saying, "It's OK, if you just use your methadone, you're going to have an OK baby," is not helping the women. The heroin is a bad enough drug. Again, these are two more drugs that get metabolized, and they're highly soluble in fat. They are excreted in breast mik and are going to cause problems for the babies.

And so that brings us into the late 70's and early 80's and cocaine. And why, all of a sudden, are we starting to see a problem with cocaine?

I think that the reason we are seeing a problem with cocaine is that, in the late 70's and early 80's when cocaine first came out, apparently what you could get for $100 was approxiamtely a weekend's supply (it depends on how much is used, of course). And that cocaine was cut a many times before the user ever saw it, the mixture was very weak, and the way it was taken was nasally, by snorting the cocaine. And the dose of cocaine that you could get from that was very small. So I think that there probably was an underlying problem with cocaine, in the early 80's, that we didn't recognize, because people were taking small doeses of it every once in a while, but they weren't taking big doses like they're getting in crack, and the crack is the problem.

Some drug addict-genius figured out that you could just mix cocaine, any strength cocaine--get it from anywhere--with baking soda and water, make a paste of it. All that stuff with Richard Pryor, and mixing it with ether and all these kinds of things that they did to make it soluble wasn't necessary. All they have to do is mix it with baking soda and water, make a paste out of it and let it dry in a microwave (so it dries faster), and what you get out of that is a hard substance, and that's referred to as "rock." This gets cracked into pieces, and what the users dose to smoke it is to put it on some kind of pipe and they use the butane lighters and vaporize that substance. This makes a crackling sound, and that's where the name "crack" comes from. What the users get, when they do that, is a pure dose of cocaine hydrochloride. No matter how weak the cocaine was when it first started out, the only thing they are geting is a pure dose of cocaine, and they can very rapidly achieve very high blood levels of the cocaine. What I understand from the users of the crack cocaine is that everything that you get from cocaine--the euphoria --is multiplied many times when you do the crack cocaine. It is a very alluring drug, to the point that people will do nothing else , and that's the

problem with crack, and I believe that's the reason why we started seeing the problem with our children.

What I always like to say, when I talk about cocaine use during pregnancy, is that I am not reporting scientific studies. More than two-and a half years ago, when I first came out publicly and said that cocaine was causing a problem in the nursery, I actually got calls from doctors around the country, who were saying that it was just for the publicity; that I had no good scientific evidence that cocaine was bad for the baby. That is a very servious problem that other doctors have sometimes with me, because my answer to the people was : "Guess what? If it turns out that cocaine is OK for babies, we'll put out a bulletin saying, "It's OK to do cocaine during pregnancy."

My problem is this: Forgetting everything else, just like with the marijuana and the smoking--just take the smoke of the marijuana, and then question whether you'd want to smoke during a pregnancy. There are women who will not take an aspirin during their pregnancy, for fear of causing problems in their babies. Yet, before we started talking about cocaine use during pregnancy, if a doctor didn't say something was bad, then people thought it must be OK. It took somebody coming out and saying the stuff was bad. Now there have been studies coming out since then that have corroborated that it is not good for babies; but, to me, this is no great scientific breakthrough. I always like to say that it seems to me that if cocaine can kill a basketball star and healthy football star--if cocaine can cause microinfarcts in the hearts of adults--what do you think it does to a developing fetus? I mean, does this take a lot of brilliance and thought to reason that cocaine is not good for babies? And yet my own friends and neighbors, when I first started talking about cocaine said, "Oh yeah? You think that's really bad?"

And I had problems with HRS! My main problem! The only reason I got into the whole thing in the first place was because, as a Pediatrician, I believe that if you saw a baby in the Emergency Room with multiple trauma, you did not have to question how the multiple trauma happened. Okay, the parents said the kid fell off of the couch, but you could still ask HRS to obtain a consult to make sure, from a public health standpoint, that it was a safe environment for the child to go back to. As a Pediatrician, you were protected. you were not only protected, it was demanded that you report that as possible child abuse. And so I felt that a child that could go home to a cocaine-abusing family would also require the same protection. And what happened was HRS was complaining

that I was putting too many consults in and abusing the system. I wasn't abusing the system. The people who were using the cocaine were abusing the system, and they needed to realize the seriousness of this problem, and I actually had HRS workers, some years ago, arguing with me that; "Well, what if they're rich?" or "Why do I have to get HRS to go out to the house if the parents only do cocaine once in a while". People don't only do cocaine once in a while. Let me tell you that someone who does cocaine doesn't care about going to the doctor for prenatal visits, doesn't care about their own body, and doesn't care about the fetus's body.

So forget anything else that the cocaine would have done to the baby. Just take bad nutrition and bad prenatal care. What kind of babies do we get when we have bad nutrition and prenatal care? We get bad babies! That's been shown time and time again. So that what the cocaine does--forgetting what the drug does to a fetus--just taking what it does to the mother as an individual, and you are going to ge a bad baby out of that. And that's the argument I have for the doctors who said that I didn't have any scientific proof that the cocaine was causing me to have sick babies in the nursery. I felt that, as a physician, I had enough presumptive evidence to warn people against using it, and so I'm saying this is not a scientific study, it is anecdotal.

In January or February of 1986, I was not looking for cocaine in every single admission, I just happened to notice that, as we made rounds in the morning, there were a lot of babies whose mothers were cocaine addicts. In our Newborn Intensive Care Unit we have 800 admissions a year, and about one in twenty babies had cocaine--either in the history of the mother or father, or in the baby's urine. Well, the problem with the crack cocaine is that it achieves high blood levels very quickly, and then it goes out of the blood system very quickly, so that--unlike marijuana, which can last in the system for long periods of time--the cocaine hydrochloride gets passed very quickly and after about two days cannot be detected in the system, so that if the cocaine is not found in the urine of the mother of the baby, it doesn't mean that she is not a cocaine addict.

What we started looking for at that time was just a history of cocaine. For instance, the women would come into the clinics with a history of a previous baby with cocaine, or identify themselves as cocaine addicts. They won't identify themselves as cocaine addicts anymore because they are afraid that the Law, or something like that, will interfere with their lives. Somehow we would get the idea and then we could start

testing the baby. So we weren't testing all babies, and we're still not testing all babies. I will tell you, later on, who we do test, but basically, at that time, we were only testing highly presmptive people, and were still finding more that twenty percent positive.

We then started looking, more and more, for what the problem was; and, as you can see, by the middle of that year of 1986, instead of one in twenty of the babies, we were finding out one in five of the babies admitted to the Newborn Intensive Care Unit had cocaine in the history or in the urine. This is a tremendous amount. I mean, I go around and I talk with as many groups as I can, but I sort of feel, most of the time, like I'm preaching to the choir, because they're all still out there doing it, and it just gets worse and worse. Now, instead of one in twenty babies in the NICU having cocaine, we now have one in twenty babies in our **normal** nursery that shows up with cocaine in the urine, and one in five babies in our Newborn Intensive Care Unit has cocaine. And in one recent weekend, every single baby I admitted to the Unit had cocaine.

As anyone who works with children knows, it gets very frustrating when the only problems you are seeing are caused by the parents themselves. One of the reasons we went into Pediatrics and Neonatology was that it wasn't the "kids' fault". While I was training in Neonatology, one of the first thing I learned to say to parents was: "There's nothing that you did that caused this problem, and there's nothing you could have done to prevent it." And you can't say that with the cocaine. They're causing their own problems, and they are causing problems that are really devastating.

It is hard to do a randomized, controlled trial for cocaine in humans, and there is very little animal experimentation that is going on. So everything we are hearing now is brand-new stuff and I don't know what's going to come of all this. Again, it is not like LSD where people just stopped using it. I have a feeling that we're going to find a lot of effects from the cocaine that people aren't going to like, and it's happening to a generation of Floridians, and I suppose it's happening in other places. When I first started talking about this, people would say, "Well that doesn't happen in our population." If it doesn't happen in your population I believe that you're not looking for it. I think that the crack addicts are identified easily after while, because they continue to use crack.

We are seeing an increased incidence of first-and second-trimester spontaneous abortions and third-trimester stillbiths. Cocaine is a potent vasoconstrictor--that's

what it does. It causes the blood vessels to shut down. At the time when the fetus needs the most amount of blood flow for the most amount of nutrition, the woman is taking the drug which causes decreased blood flow, and when enough decrease is caused in the blood flow to the placenta, what you are going to get is a placental separation. And, again, it's anecdotal, but you hear stories all the time where the woman just finished with her secsond or third binge of the crack, and then she came in with an abortion.

I refer you to a recent article is in The Journal of Pediatrics, January, 1987 entitled "The Teratogenicity of Cocaine." Teratogen is a Greek word meaning "monster-producing". What I read in that article was that they had three groups of women in East Harlem One group consisted of multi-drug abusers; one group was cocaine abusers; and there was a control group of women who were not supposed to be drug abusers. The results were that the group of women who did cocaine exclusively had the worst outcome with pregnancy. The feeling in the study was that the reason was because the multi-drug users used a little of everything and never got high blood levels of any particular drug; whereas, the cocaine abusers were always abusing the same drug, and causing the problems with babies. The prematurity would be analagous to a spontaneous abortion that lives, instead of being a third-trimester stillbirth. We see a lot of those babies, especially twins. Twins tend to be born prematurely anyway, and we've had a lot of sets of cocaine twins now, where the mothers do high does of cocaine, and then they come and deliver their babies prematurely.

Just three years ago, the chances of a 1 to 2 pound baby surviving was one in ten. At Broward General Medical Center, presently, the chances of survival are now six in ten. So what's happening is that we've been able, through technology, and through the work of Neonatology, to have smaller and smaller babies survive.

As a Regional Pernatal Intentive Care Center, in Broward County, we're mandated to have a follow-up clinic; and what we were hearing from our follow-up people was that the same 7 month baby where there was cocaine, versus one where there was no cocaine, was not doing as well neurologically. That was also mentioned in the New England Journal, two years ago, where they showed that babies had developmental problems when their mothers took cocaine during their pregnancy.

We also were noticing an increased incidence of strokes in our cocaine babies. We had two babies born with only half a brain. I have never, in twelve years, seen babies

born with such devastating intrauterine strokes as when the mothers were high-dose users of crack cocaine. That's how the babies presented, at birth, shortly after the mother had used crack cocaine.

The birth defects are different in different studies. The birth defect that we were seeing most often at Broward General--and we are still seeing it, and it's still not being written about yet--is gastrointestinal. Anybody who takes care of babies knows that the most important thing to the grandparents of the babies is stooling and feeding and babies that are cocaine babies don't do either normally. They don't do those two basic things that a little baby has to do right. When you try to feed them, they don't interact well with their caretaker. They don't suck very well. They don't stool for days at a time, and that becomes a problem. If the baby doesn't stool for the first 48 hours, a high percentage of thoses babies have anatomical problems. If cocaine is detected, I don't have to do a rectal biopsy; I can just wait. And that's somethng we are definitely seeing.

The addicted infants are something that the Press is always asking me about but actually that is the least of their problems because a cocaine-addicted infant gets over the drug in about one or two weeks. As I told you, the drug gets out of the maternal system in about two or three days at the most. It metabolized in the liver, and so infants, who metabolize in the liver more slowly tend to keep the drug up to two weeks. If you just leave the babies in the nursery for a couple of weeks or a month, they'll all do OK. The cocaine will go away. I have given two babies phebnobarital to calm them down because they were so jittery , but this is rare.

The child get over the general addiction pretty quickly. I frequently speak with adoptive families because nowadays a lot of women who give away their babies are drug addicts, and they are cocaine addicts down in Fort Lauderdale. The following scenerio is what I often describe:
You're in the supermarket, two or three weeks after adopting a baby, and the kid is in the pushcart, and somebody comes along who didn't know the baby was adopted and they will say, "Oh, you have a new baby. It looks just like you." It happens all the time to adoptive parents that other people think the baby looks just like the parents. And I don't think that they are just patronizing those people; I don't think that they're just being condescending. I think the babies really do look just like the parents, because

anybody who has obseved newborns knows that if you stick your tongue out to a baby, he will stick out his tongue just like you did. If you furrow your eyebrows at the baby, the baby will imitate your behavior exactly. And what happens is, after the kids are home from the hospital, after six or eight weeks, I'll get a call, from around the country, (usually on a Friday night at two o'clock in the morning when the infants are dumped in the Emergeny Room) from a Pediatrician who'll say, "I've got a baby here, and I want to know if it's a cocaine addict, because the kid is awfully jittery. He's acting just like an addict." They are acting like addicts. They act just like little addicts because their parents are big addicts. They are not addicted to the drug. They are just imitating their parents behavior! It probably happens something like this: When a baby cries, he needs to be picked up, he needs to be cuddled, he needs to be changed, he needs to be fed. Something has to be done to pay attention to the baby when it's crying. That's the normal behavior of a human toward an infant. What happens is, when you're stoned out of your mind and the baby cries you just ignore it.

The next scene shows the caretaker needs a dose of cocaine. They're very jittery, they're very easy to upset, and the cocaine baby tends to have a little bit of strong high-pitched cry, and is not easy to sooth. Those babies get beaten when they start to cry. I've seen four babies, at Broward General, last year, with fractures, from parents who were cocaine addicts, and you could have predicted it. You know, what is she going to do when she's just beside herself? Anybody that takes care of babies, you know the feeling you can get sometimes. If you took care of this baby yourself, you might want to beat this kid. People who take drugs are not going to have a normal level of self-control, and that is when they are going to hit the child, so those babies are at incredibley high risk for abuse.

One thing that came out about NICU babies, in the 70's, that was surprising to people, was that everbody thought that when a baby went home from the NICU it would be a really loved baby and a special baby in the home. And what has been found is the babies that go home from the NICU tend to be the weaklings of the family, the scapegoats of the family, and they tend to be at higher risk for abuse and neglect, just because they went home from an NICU. And then there were a lot of people who thought there was a bonding problem, and they tried to encourage bonding in the Nursery. In general, if you just look at the statistics, babies going from NICU's are at higher risk for abuse and neglect.

If you take that, and then you multiply all that by the problems that you have because of the drug addiction, I have come to believe, over the years, that 100% of the babies are at risk. You know, I used to get asked the questions,"Well, how many of these babies are abused?" If the mother is doing the drug--if the family is doing the drug--then 100% of the babies are at risk for abuse and neglect. Because what the parents care about is the drug, and not the baby, and a normal family is supposed to care about the baby and not the drug. And so 100%--all of them--are at risk! It' not a matter of how much, and it's not a matter of recreational use. And I believe we are producing a generation of people with lowered intelligence, and I'll show you why I think that.

What I've done on this slide is I keep updating it to try to include all the information from the literature that shows a proven problem with cocaine during pregnancy. And what this is a synthesis of all the studies. Now, it's rare that a three-pound baby has cerebral bleeding so severe that it causes "water-on-the-brain". But a one-pound baby, nowadays, is getting the old problems of lung disease and bleeding that the three-pound babies used to get. So when these babies are born prematurely, you're seeing a lot more intraventricular hemorrhage than we used to see two or three years ago. As we started saving the smaller babies, we thought that we were saving babies who were going to remain intact. We always used to say that if the baby survived, it had a 90-95% chance of being intact. In the 50's, when they were saving those little babies, they had a very poor chance of remaining OK. It wasn't untill CPAP, in the 60's, that the babies had a chance of having developing more normally. And so the problem of intraventricular hemorrhage and hydrocephalus are seen time and again in the babies of the mothers who are cocaine addicts.

As for the low birth weight -- Again, I don't know if it is because the mother had poor nutrition, or because the mother is causing decreased blood flow to the placenta at the time when the baby needs it most, or because she has just not, generally, been taking good care of herself and gone to prenatal clinics. I don't care what the reason was for the baby's low birth weight. But the babies do have low birth weight; and that, in itself, would not be bad, nor would the decreased length. What worries us is the decreased head circumference.

I work in a follow-up clinic where we just see medical problems of our babies, at a month to two months after discharge from the Intensive Care Unit, and these babies of cocaine Moms have tiny heads. What worries us here, is that in previous studies,

excessively small heads have been associated with mental retardation and cerebral palsy. I don't have proof, yet, that a baby with a small head is not going to be smart. But all the literature, so far, points to babies with small heads having handicaps, and that is a worry, because there is nothing you do to fix that. And when I speak to adoptive parents or Pediatricians, my best advice for whether or not that child may develop normally is to check the head circumference. Now, that doesn't mean don't take the babe home. After all, any adoptive parent is just trying to do the best for the baby, and the baby will be better in caring hands that anywhere else.

You see, if I'm having one in five babies from the Newborn Intensive Care Unit coming out that way, I'm talking about a possible 20% incidence of mental retardation just because of the cocaine. And we weren't talking about 20% mental retardation out of our entire NICU population a couple of years ago. We were telling parents that they were going to come out OK, and I don't know what to tell the parents anymore. Especially with the medical/legal situation in Florida, where parents and attorneys are searching for any reason why their baby is imperfect. I'll tell you, that's the reason why I want to do cocaine screening for as many babies as I can, because if that baby doesn't come out all right, and I find out there is cocaine in its urine, the mother is going to have to explain that before we place blame on the Pediatrician or the Obstetrician. At least if you can have proof that there was drug abuse during the pregnancy, that's going to have to be explained. And what I tell the physicians, when I speak to a physicians group, I would test as many babies as I could just for that reason alone.

The increase in congenital malformation is a general, overall increase in congenital malformations that nobody can explain. And we have seen that, too, at Broward General. They have everything. Again, it's not scientific, but we see some of the crazy congenital malformations that we can't even explain when the mothers are doing cocaine during their pregnancy.

The withdrawal syndrome, I talked about. It is mild; it will go away. But the important thing about the withdrawal syndrome is that's the time the baby is going to be the most irritable and a poor feeder. So people have to know that. Sometimes, when I give this talk, people ask me: "What is the advice you would like to give to people when they are going to have a baby that is a cocaine baby?" If you know that those babies are going to be affected, and they are going to be hard to feed, and they're going to be hard to nurture, maybe you could be a little more tolerant of their behavior. And many times

what we have done is ask the grandparents to take care of these babies for some amount of time; and, on a public health level that has helped us, because, after all, what are we going to do with all these kids? There is no place for them to go, and so they're going to end up taking care of the mother and the baby.

There was a time, when we first started seeing the problem, when we saw it in all populations. The main problem that I was seeing was cocaine abuse and it could affect rich people, poor people, black, white or Hispanic. I am now seeing it in a much poorer population, and the association which is coming up time and time again, now, and which is not on the slide as yet, is veneral disease. It is greater than 70% at present. If I find venereal disease in the mother and I can test for cocaine I'm going to find it. And I'll tell you, so far I'm not doing AIDS testing on all these babies, because I don't know exactly what I'm going to do with them if I find AIDS. But on the infants where we have started doing some AIDS testing, some are coming out positive. The lifestyle of these people who are crack addits is such that they are getting every disease, and they are transmitting it to their babies.

My social worker even made the diagnosis of crack addiction one day, because a woman came in with these terrible scratch marks all over her legs. She was not identified as a cocaine addict, and the baby was positive; but it turns out is that drugs addicts get a hallucination called formication, and it is the hallucination that you have bugs on your body, and you scratch them. Another way I pick up cocaine now is the lack of prenatal care; and, again, if you thought the woman had no prenatal care, do a drug test and a test for venereal disease and you are going to find stuff. We're getting penicillin-resistant gonorrhea in Fort Lauderdale, which is a really difficult organism to treat, and these people have multiple sexually-transmitted diseases, and it's really kind of a frustrating thing to take care of babies with all these problems. You're wearing gloves, and the parents have to wear gloves, and people are wearing masks and everything, because you're scared to catch what the kids may have.

So I now test infants where the mother has had no prenatal care, venereal disease, infants-for-adoption, and any abnormal behavior. Unfortunately, this is a large percentage of our patients.

The low Brazelton score is something that I was alluding to earlier. For all intents and purposes is a neonatal IQ test. It is not a very good test, but this is the one of the few

tests available for predicting development. When the infants of cocaine addicts were compared with those whose mothers were not cocaine addicts, the Brazelton score was lower. I don't know if it's going to hold true, but that should be a cause for concern.

Also, there is this terrible interaction where these babies who were not doing so well go to a home where the mother is not going to be waiting for that child; the mother is not going to be doing the normal things that it takes to raise that child and make that child OK. How can that baby have any chance of normal development if --forgetting the small heads that they're starting out with --they are placed in an abnormal environment?

What happened in the last two years is that the Legislature, in Florida, has been working on the issue. There is already a statute, in Florida, that if there is threatened or actual abuse or neglect, there may be intervention on the part of the State. However, the HRS, in the State, has chosen not to obey that "threatened or actual" when it comes to cocaine during pregnancy. I'm sure the reason that they've chosen that course is simply because they are an overworked and underpaid body, anyway, and there is no way they can address all of these problems.

I'd like to spend the last few minutes of this talk telling you my feelings, politically, about what is going on here, in Florida. I'm glad a law identifying these cocaine addicted families has passed; I can now, at least, get a public health worker going out to the house. What needs to be done now is the following:

1. The family has got to get off the drugs.
2. The most important thing is that the kids have to be protected.

And thoses two things are not being done at this time. The kids are not being protected. About six months ago, in Fort Lauderdale, there was a woman who was found to be giving her child cocaine two weeks after delivery. She was a cocaine addict and apparently she thought the baby was doing better when she gave a little bit . There was no problem putting that woman in jail. However, if the woman takes cocaine the day before her delivery--well, now, we're not going to step on her rights to do drugs! That is clear, that you can't do anything against if she takes cocaine the day before her delivery.

My argument is, and the argument of doctors who have dealt with these people is, she has given that baby drugs; and at some time we have all got to come to the conclusion that there are rights that must be given up, when a woman becomes pregnant, in favor of the rights of the infant. Whenever that becomes an infant. I get asked to talk sometimes to Right to Life groups and organizations like that. I'm not necessarily for, or against, that issue. To me the point is, whenever it is decided that that fetus is a human being, they are giving drugs to a human being that doesn't want them. If you had the ability to ask that child would they want to go live with these people, they would say, "No way! These people are nuts! I don't want to go home with them." And it is our job, as children's advocates, to lobby for those children, in one way or other, so they don't have to go home with these familes. A law that just identifies these people is only the very beginning.

We've asked, for instance, for $400,000, in Broward County, for a one year project to help these women and their infants. This could reach 250 women. Some would have inpatient counseling--they would actually go into a center; and 200 women would have outpatient counseling. It was the Children's Consortium who requested that money.

But the point is that it is going to take money, because--for instance, in Broward County, there is only one publicly supported program where a woman can go when she wants to get off drugs. It is called Broward Addiction Rehabilitaion Center (BARC). If she choose not to go and get an interview at BARC, she doesn't have to. If she goes to BARC and then goes back on the drugs nothing is going to happen to her. Once the public health worker went out to the house, that was the end of the story.

Just recently I was asked how the law working out. I don't even understand what the law is. All it does is to identify the child. How does that change what is going on? I have not seen one commercial on television; I have not seen one advertisement for not doing drugs during pregnancy. You will see stuff for not doing alcohol. You'll see stuff for not doing cocaine for yourself. But nobody says not to do cocaine during pregnancy--that it is going to cause a malformed baby.

So that's the first part. The first part is to get some real counseling for the mother, and the only way to get real counseling is that there has to be money to put into that. When a woman decides to go into counseling, if she has the means, there are drug rehab centers that she can go to; but, if anyone knows anybody who went to a drug rehab

center, they probably know it is a very difficult to get off the cocaine. It will take more than just one little center--BARC--in all of Broward County, to handle this problem.

There is little protection for the child at this time. The only way the child can be removed from the home is if there is actual abuse. In other words, when the child has a skull fracture, **then** we can do something about it. And you will hear this from HRS workers, time and time again, that there's no proof that the child wasn't doing well. Now that the mothers know that they're going to be checked, that the public health worker is going to go out to the house, what we now see is a new problem. The mother feeds the baby. They don't want the public health workers to come out to the house and see an emaciated little baby. So what they do is, every time the kid cries, they just stick a bottle in his mouth. Now I have kids coming to follow-up clinic that have these big fat bodies and little heads, and they hardly move. And they don't get identified as "failure to thrive" by the system, because they haven't failed to thrive; they're growing. And the protection of these children is something that we are not even beginning to address. So the question that I get asked is, "Well, what are you supposed to do? Are you supposed to take them out of the home?" My answer is "Yes!" If there is cocaine being abused in the home, yeah! Every single one of them has to be taken out of the home until the cocaine is not being abused. And it has taken me years to come to that conclusion. I mean, it's just that you have to see these people. They're so stoned, they come in and they don't even know they delivered babies. They can't care for the infant until they're off the drugs.

So, the end of my speech always is: When you elect our Legislators, be aware of what they have actually done for the problems of social issues in Florida and not the occassinopal lip- service or laws that don't have any real bite, and maybe we'll able to effect some changes.

COCAINE STUDY

MONTH	TOTAL ADMIT	CONCAINE	%
February	40	2	5
March	37	1	2.7
April	52	3	5.7
June	48	3	6.25
July	45	3	6.67
August	82	10	12.2
September	72	16	22.22
October	64	12	18.75
November	71	14	19.72
December	55	9	16.36

COCAINE ABUSE IN PREGNANCY

SPONTANEOUS ABORTION

PREMATURITY

STROKES

BIRTH DEFECTS

ESP GASTRO-INTESTINAL

"ADDICTED" INFANTS

ADDICTED FAMILY

ADVERSE EFFECTS OF PREGNANCY

INCREASED STILLBIRTH RATE

INCREASED SPONTANEOUS ABORTION RATE

STROKES

ABRUPTIO PLACENTA

LOW BIRTH WEIGHT

DECREASED LENGTH

DECREASED HEAD CIRCUMFERENCE

INCREASED CONGENITAL MALFORMATIONS

WITHDRAWAL SYNDROME

LOW BRAZELTON SCORE

HIGH RISK OF ABUSE AND NEGLECT

COCAINE CRISIS IN THE FAMILY

ESTHER D. MARCH, R.N., B.H.S.

Dear members of the Select Committee on Narcotics Abuse and Control, my name is Esther March and I am the Discharge Planner and Parent Educator in the Neonatal Intensive Care Unit at Broward General Medical Center in Fort Lauderdale, Florida.

I have worked in the Neonatal Intensive Care Unit for many years. As the Discharge Planner and Parent Educator I function as a liason between the community and hospital systems preparing for the infants' discharge. Many of these infants require special medical care at home and their parent(s) must learn additional caretaking skills in order for the infant to thrive. My job is to prepare parents to care for these infants' special needs at home and to link them with a multitude of supportive community agencies for follow-up care.

With the birth of a premature or sick newborn, there is a series of psycho- social problems or crises that the parents must face. These problems or crises can, and many times are, worked out by the parents before the infant is discharged. What concerns me the most is the unresolved psycho-social problems that many of the neonatal parents are faced with because of their cocaine addiction. They often have unstable housing, few resources and are functioning at such a low level that they cannot, or choose not to, seek public assistance.

These parents' physical condition, lack of motivation, and lack of attachment to their infant, makes it very difficult to teach the many special skills that are needed for their infant's home care. In the Neonatal Unit, many cocaine addicted parents have displayed their inability to care for their infants because of their rapid mood changes, their lack of coordination, and the fact that they often cannot recall information that is vital to the infants survival.

I am aware that a referral system was implemented last year to address the problems dealing with pregnant women and cocaine abuse; however, this program has not met the community needs. Many babies are still being discharged to mothers who have not received any drug treatment

either because they have refused to acknowledge their problem, or because of a lack of available inpatient beds for the indigent population.

Case Example:
I recall a situation that happened two weeks ago when a mother gave birth to a premature baby boy. The baby remained in the hospital for 7 days. Because of the mothers drug history and baby's positive urine test for cocaine, a Public Health referral was made. A home investigation was performed, and the report revealed open drug activity going on between the baby's mother and three men. Two days later a second home investigation was performed which revealed no open drug activity at that time. The home investigation was deemed satisfactory for the infant's discharge. This mother came to the hospital for the infant's discharge without any baby supplies or equipment, and alcohol was noted on her breath. The child was released to the custody of his mother with only Public Health follow-up.

Another case example is a single mother who gave birth to a severely premature male infant who remained in the hospital for 3 months. The child was ventilated and required multiple procedures which required parental consent. Because of the mother's lack of contact with the NICU, and her unstable housing situation it was nearly impossible to locate her in a timely manner for ongoing consultation regarding her infant's progress and medical treatment. Throughout this baby's 3 month hospitalization the mother visited 3 times. She got minimally involved in his care despite encouragement and support for this by nursing staff. Upon discharge, this infant required medication and an apnea home monitor. I made several appointments for teaching of CPR and home monitor training which the mother did not keep. After being threatened with an abandonment referral to HRS, the mother showed up 4 days after the scheduled discharge date to take her baby home. This mother marginally completed required training for her infant's care, but was noted to fall asleep while feeding him. Despite my feeling of uneasiness in releasing this child to his mother, the system as it now exists, left me no recourse but to discharge this child home.

I feel that these two babies and all other babies with similar circumstances should be protected by the legal system until the parent receives treatment for their drug addiction. These infants are at very high risk for abuse and neglect, and in many cases, because of the powerful addiction, the driving force in the parent's life is the substance that they are addicted to, and the parent's drug needs will be given priority over the needs of their infant. Treatment should be court ordered when the mother refuses to acknowledge her problem and until treatment is completed the children should be placed in legal custody of a significant other or in an alternative care situation. This will ensure the protection of the children and provide support for the persons who are often put in the position of primary caretaker because of the mother's dysfunction. In many cases, these significant others lack legal support to safeguard the child and make important decisions related to the child's needs because they are not considered legal guardians.

In summary, the drug referral system has been an asset in identifying many high risk drug cases, but there is a tremendous need for legislation of resources' to help treat the parent(s) with the addiction and to place the infant in a safe environment during the parent(s) treatment process. Within the present legal system, only those drug addicted infants who are abandoned, may be referred to protective services from the hospital setting. I believe the future of our country depends upon the healthy, physical and emotional development of our children. Therefore, these children who are at such great risk deserve the support for a positive environment in which to thrive. Thank you for your attention and concern for this vital issue.

Esther D. March, R.N., B.H.S.
Discharge Planner/Parent Educator
Newborn Intensive Care Unit
Broward General Medical Center

TESTIMONY PRESENTED

TO THE

SELECT COMMITTEE ON

NARCOTICS ABUSE AND CONTROL

OCTOBER 16, 1987

BROWARD GENERAL MEDICAL CENTER

FORT LAUDERDALE, FLORIDA

Submitted by:

Myra Lentz Bomba
Deputy District Administrator
HRS District 10
Fort Lauderdale, Florida

BACKGROUND STATEMENT:

In the latter months of 1985, a form of cocaine known as "crack" became popular with drug users in big cities around the country. By the middle of 1986, its effect was being felt throughout Florida and particularly in the southeastern counties along the famous "gold coast." Broward County, identified as a gold coast county, generally associated with wealth, beaches, yachts, waterfront mansions, swaying palm trees and beautiful sunsets, has its share of economic, social and health problems. Even before "crack" cocaine use became epidemic, publicly funded agencies such as the Department of Health and Rehabilitative Services were already overburdened with trying to keep up with the increased demands for services that came as a result of being one of the fastest growing areas in the country. With an estimated population of 1.2 million, Broward is currently the second largest county in the state. Dade, Broward, and Palm Beach counties combined comprise 34 percent of the state's population. All of the problems associated with large metropolitan areas of the country can be found here, compounded by Broward being a port of entry for illicit drugs from other countries.

The Florida Department of Health and Rehabilitative Services is organized into eleven districts of which District 10 is Broward County, the only one-county district in the state. The Department has broad statutory responsiblities which both directs and limits the provision of health and social services in the state, with each District functioning within state rules and regulations in program implementation at the local level.

Specifically, one of the areas that has been a major local concern over the last 20 or 30 years is the high infant mortality rate in Broward County. In spite of organized effort through federal grants for maternal and child health under the Social Security Amendment; additional state dollars for improved pregnancy outcome; and additional local county appropriations for this purpose, our infant mortality rates were consistently higher among the non-white population than the state rate, and the comparative rate of other southern states. Included in your material, there is a data sheet providing information regarding the rate for Broward since 1970. Although both the white and non-white rates have declined, the non-white continues to be twice that of the white.

Part of the problem in maternity services is that we never seem to catch up with the increased demand for services. For example, in 1976 Broward had 8,789 live births and the mortality rate for whites was 10.3 per 1000 live births; for non-whites it was 28.7 -- more than double the white rate. Ten years later the rates were down but still the disparity between white and non-white existed. In 1986, there were 15,034 recorded live births with the infant death rate for whites 8.7 per thousand and non-whites 19.2 per thousand live births which is still more than double.

Each year, the number of births increase, the need for access to prenatal care increases and the system is slow to respond to demands for service. Approximately one third of the total births are to mothers who ved subsidized maternity services. There have been statewide initiatives which

began in the early 80s to deal with low birth weight, which still is the major cause of infant deaths.

Then, as stated earlier, during the spring and summer of 1986, there was an increased concern among the providers of maternal and infant care services to mothers and babies, and community leaders as well, that the use of drugs, specially cocaine, was becoming a very severe problem. There was also a high level of frustration among all of us who were trying to respond to this new problem while still trying to solve existing ones.

In July of 1986, Congressman Shaw, as a member of this select committee, toured the neo-natal unit at Broward General Medical Center with Dr. Udell and today, you, the select committee are hearing testimony in Broward concerning this problem and how a community worked together to address mutual concerns.

I do not want to suggest that it was easy to develop the community network program that now has been referenced as a model program. But, I do want to emphasize that all of the providers, community leaders and involved agencies worked together and never lost sight of the overall goal which is to protect children.

RESPONSE TO THE PROBLEM:

Because of this rapid increase in cocaine use and abuse, as well as the increase in the number of babies born addicted to the drug, the Department of Health and Rehabilitative Services, District 10, organized a "cocaine babies" work group in the fall of 1986 to develop procedures to follow in relation to

the needs of these women and their babies. Additionally, an interagency Maternal and Child Health Task Force was also created to focus on the need for comprehensive prenatal care for all pregnant women.

The work group and the task force were both composed of representatives from Broward General Medical Center, both the Regional Perinatal Program and the Well-baby Nursery, the Visiting Nurses Association, Broward County Public Health Unit, Broward Addiction Rehabilitation Center; Alcohol, Drug Abuse and Mental Health Program Office; Children, Youth and Families; and Children's Medical Services.

The work group developed procedures during its initial meeting, including a start-up date. Followup meetings were held to discuss any problems being experienced and to insure that the women and their babies were being followed appropriately and receiving the necessary support services. During our followup meetings, it was determined that one of the biggest problems was the need for additional staff to handle the increase in the number of clients requesting or being referred to the Broward Addiction Rehabilitation Center for treatment. Because of this problem, the group submitted a request for funding to the Alcohol, Drug Abuse and Mental Health Program Office. One position was identified to assist in this effort.

The informal procedure that was developed by the work group was put into effect and continued from November 24, 1986 until Secretary Gregory Coler issued a departmental policy which was effective March 9, 1987. The policy provided for a system of identification, reporting and provision of needed

services to drug or alcohol involved newborns and babies born to mothers who are addicted or abusing drugs or alcohol. A copy of this policy is included in your packet of materials. The major difference in the informal system and the departmental policy was the implementation of specific time standards for visits to be made to the discharged infant.

Since implementation of this policy on March 9, 1987 and until September 30, 1987, the public health unit received some 400 at-risk referrals from 6 referring hospitals. Of the 400 referrals, 164 were to infants born to mothers with a history of substance abuse and/or had positive laboratory tests for illicit drugs in the body of the infant and/or mother. Out of these 164 infants, 28 were referred to single intake for investigation of potential neglect. It is also interesting to note that out of the 164 babies who needed intensive followup only 65 of the mothers had received prenatal care.

For substance abusing groups, the initial contact with the mother is made prior to discharge from the hospital when possible; otherwise, the nurse visits the mother's home within 48 hours post discharge of the infant.

It is felt that this activity of home visiting of the at-risk infants and their mothers is of benefit. The process of early identification of an adequate support system for the mother and infant, and in some instances identifying another caregiver other than the mother, is definitely a positive value. Prior to the initiation of this followup system, the identification of the support sytem was often left to chance.

One of the most troublesome problems encountered with these families is the need for safe and adequate low-cost housing. Even when another relative assumes responsiblity for these infants, often the infant is taken into an already over-crowded, inadequate home.

Another serious problem occurs when a relative assumes the care by common consent of these infants. The question of legal custody surfaces as these relatives cannot sign or give legal consent for medical and health care for the child. Establishment of legal custody, even temporary, can be a long and costly process for someone who has volunteered to care for the infant.

The availability of inpatient beds at drug treatment centers is limited; often the mother has to wait for an inpatient bed. It is difficult at best to motivate some of these mothers to accept treatment and when they do seek inpatient care and have to wait, they likely will revert back to their previous lifestyles.

The time required to followup these infants has required the public health unit to reorder its priorities. Most of the professional nurses feel personally responsible for the "life" of these infants and they are making many non-health related visits to the home just to "check up" on these infants. These feelings of being responsible for the life of the infant has increased the stress levels of the nursing staff and "burnout" syndrome is evident.

Some recommendations for improvement of the service continuum that has been developed can be accomplished at the local level with continuing interagency cooperation. These include:

- Initial home visit should be a team effort conducted by a worker from Voluntary Family Services and the public health nurse.
- Ensure needed support and services for family members who are the primary caregivers of infants born to substance abusing mothers.
- Increase communication among all the providers of services to the infant and mother.

There are other recommendations for improvement of the sytsem which require intervention at a higher level, within the legislative or congressional attention or both. These include:

- Development and implementation of a universal maternity care program at the national level which ensures that high quality maternity care be available and accessible to all pregnant women in the United States.
- Provision of adequate funding to address the nation-wide drug problems, including prevention, treatment, and rehabilitative services.
- Provide residential drug treatment programs for pregnant women before and after delivery.
- Increase the availability of low income housing for young families.

We appreciate the opportunity to provide information for your consideration and remain hopeful that these needs of our women and children can be addressed.

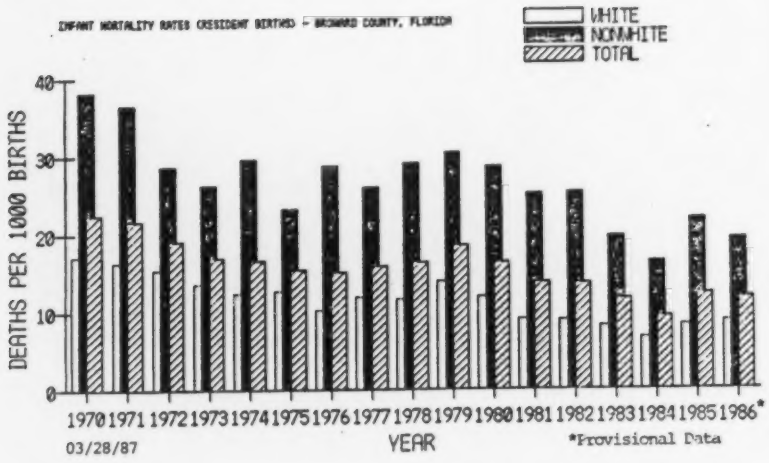
HRS - DISTRICT TEN - BROWARD COUNTY PUBLIC HEALTH UNIT

Rundate: 03/20/87

INFANT MORTALITY DATA (Rate per 1000 Live Births) - Resident Births

	BROWARD-			FLORIDA-		
	LIVE	INFANT DEATHS:		LIVE	INFANT DEATHS:	
	BIRTHS	Number	Rate	BIRTHS	Number	Rate
1970						
WHITE	7101	123	17.1	86945	1537	17.7
NONWHITE	2462	94	38.2	26166	927	32.9
TOTAL	9643	217	22.5	115113	2466	21.4
1971						
WHITE	7127	117	16.4	86582	1481	17.1
NONWHITE	2514	92	36.6	29907	925	30.9
TOTAL	9641	209	21.7	116494	2408	20.7
1972						
WHITE	6416	99	15.4	81452	1312	16.1
NONWHITE	2436	70	28.7	28517	786	27.6
TOTAL	8852	169	19.1	109970	2098	19.1
1973						
WHITE	6616	90	13.6	79762	1294	16.2
NONWHITE	2360	62	26.3	27963	752	26.9
TOTAL	8976	152	16.9	107726	2047	19.0
1974						
WHITE	7244	90	12.4	82156	1139	13.9
NONWHITE	2431	72	29.6	28244	770	27.3
TOTAL	9677	162	16.7	110404	1909	17.3
1975						
WHITE	6432	82	12.7	78184	1092	13.8
NONWHITE	2284	53	23.2	27537	790	28.7
TOTAL	8716	135	15.5	105735	1873	17.7
1976						
WHITE	6419	66	10.3	76567	927	12.1
NONWHITE	2369	68	28.7	28040	647	23.1
TOTAL	8789	134	15.2	104613	1574	15.0
1977						
WHITE	6826	82	12.0	80947	983	12.1
NONWHITE	2536	66	26.0	29670	733	24.5
TOTAL	9374	149	15.9	110883	1717	15.5
1978						
WHITE	7121	83	11.7	82304	958	11.6
NONWHITE	2698	78	28.9	31033	634	20.4
TOTAL	9823	161	16.4	113367	1592	14.0
1979						
WHITE	7580	106	14.0	88712	1091	12.3
NONWHITE	2904	88	30.3	32403	716	22.1
TOTAL	10497	194	18.5	121145	1809	14.9
1980						
WHITE	8397	100	11.9	96509	1135	11.8
NONWHITE	3118	89	28.5	35294	779	22.1
TOTAL	11519	189	16.4	131811	1915	14.5
1981						
WHITE	8589	78	9.1	101038	1055	10.4
NONWHITE	3515	88	25.0	37450	792	21.1
TOTAL	12105	166	13.7	138521	1847	13.3
1982						
WHITE	9028	80	8.9	106217	1074	10.1
NONWHITE	3654	92	25.2	38253	779	20.4
TOTAL	12687	172	13.6	144500	1855	12.8
1983						
WHITE	9095	75	8.2	109905	1065	9.9
NONWHITE	3839	75	19.5	39115	728	18.6
TOTAL	12942	150	11.6	149062	1815	12.2
1984						
WHITE	9844	66	6.7	115949	984	8.5
NONWHITE	3915	64	16.3	39332	696	17.7
TOTAL	13767	130	9.4	155344	1681	10.8
1985						
WHITE	10294	85	8.3	122069	1120	9.2
NONWHITE	4331	95	21.9	41618	718	17.3
TOTAL	14630	180	12.3	163732	1846	11.3
1986**						
WHITE	10547	92	8.7	124682	1093	8.8
NONWHITE	4483	86	19.2	42353	750	17.7
TOTAL	15034	178	11.8	167071	1844	11.0
1987						
WHITE						
NONWHITE						
TOTAL						
1988						
WHITE						
NONWHITE						
TOTAL						
1989						
WHITE						
NONWHITE						
TOTAL						

** Provisional Data obtained from Vital Statistics
March 19, 1987


INFANT MORTALITY RATES (RESIDENT BIRTHS) - BROWARD COUNTY, FLORIDA
WHITE
NONWHITE
TOTAL
DEATHS PER 1000 BIRTHS
0
10
20
30
40
1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986*
YEAR
03/28/87
*Provisional Data

Office of Program Policy Development

Drug or Alcohol Involved Newborns and
Babies Born to Drug or Alcohol
Addicted or Abusing Mothers

Policy

A. Purpose: This policy provides for a system of identification, reporting and provision of needed services to drug or alcohol involved newborns and babies born to mothers who are addicted or abusing drugs or alcohol.

B. Effective Date: March 9, 1987

C. Procedures:

1. Each District Administrator shall contact local public and private hospitals, in writing, notifying them of this policy and a single district-wide number (e.g., number for the Office of Client Support Services, or District Health Program Office) that the hospital should call to refer an infant with significant drug or alcohol levels or whose mother is addicted or abusing alcohol or drugs. (A model letter is attached.)

   a. The office where the contact telephone number is located will be responsible for immediately reporting the referral to the appropriate county public health unit.

   b. The district shall also arrange for a back-up number for after hours and weekend coverage, e.g., a county public health unit, Child Protection Team.

2. Hospitals should refer these infants to the department well in advance of the infant's discharge.

3. Within 24 hours of the hospital's referral, the appropriate county public health unit shall contact the referring hospital, discuss the case and obtain the following information.

   a. Drug/alcohol symptoms of the infant and any medical complications;

   b. Home address and phone number of mother (upon discharge); and

   c. Projected (or actual) time and date of mother and infant discharge.

4. A public health nurse shall conduct a home evaluation prior to the hospital discharge of the infant whenever possible.

5. Within ~~72~~ 48 hours of the hospital discharge of the mother and infant, a county public health nurse shall make a home visit and assess the service needs of the infant and family, including an assessment of the medical conditions of the infant, environmental aspects of the home and parenting capabilities.

6. The public health nurse will serve as the case manager and will make referrals for services as needed. Such services may include medical services; Aid to Families with Dependent Children (AFDC); food stamps; Women, Infants and Children (WIC) nutritional services; alcohol or drug abuse treatment; mental health services; child support enforcement; developmental services; Children's Medical Services; or Child Protection Teams. If it is determined that there is potential of abuse or neglect, the Pre-Protective Services program of Children, Youth and Families (CYF) should be contacted. If there is evidence of abuse or neglect, CYF intake should be called and the case handled as an immediate response case.

7. Programs to which these infants and mothers are referred shall be responsible for assessment and provision of eligible and appropriate services as a top priority. Programs are responsible for providing follow-up information to the public health nurse regarding disposition of referral and periodic reports as to services rendered.

8. The county public health units shall follow these infants as part of the routine infant/childhood care and well-baby programs.

D. Reporting Requirements:

1. Districts shall monthly, beginning April 1, 1987, submit to DPO a Referral Log (copy attached). Reports are due April 1, May 1, and June 1. Thereafter, reports will be due quarterly.

2. The Referral Log shall include the following information for each infant referred:

   a. Time and date of referral;

   b. Name of referring hospital;

   c. Name of the infant;

d. Time and date hospital contacted after initial referral;

e. Time and date infant discharged from hospital;

f. Time and date of pre-discharge and post-discharge home visits; and

g. Disposition of referral (e.g., mother and father referred to drug treatment program and infant referred to CMS.)

3. In cases where service barriers or problems are identified by the public health nurse, representatives from the appropriate district program offices will meet to resolve the issues.

4. Districts shall develop procedures as necessary to implement this policy.

ROBERT B. WILLIAMS
Acting Assistant Secretary
for Programs

3/4/87
DATE

Questions regarding the policy or this memorandum should be directed to Jill Sandler, Office of Program Policy Development (PDP), SunCom 278-2761.

for J. DAVID SELLARS
Deputy Secretary
for Operations

ROBERT B. WILLIAMS
Acting Assistant Secretary
for Programs

cc: SEC (Gregory L. Coler)
Program Directors

District _____ Date _____

Referral Log

Drug or Alcohol Involved Newborns and Babies
Born to Drug or Alcohol Abusing/Addicted Mothers

Name of Infant: _____
Time & date of referral: _____
Name of referring hospital: _____
Time & date hospital contacted after initial referral: _____
Time & date infant discharged from hospital: _____
Time & date of home visits: pre-discharge _____
post-discharge _____
Disposition of referral: _____
_____

District _____ Date _____

Referral Log

Drug or Alcohol Involved Newborns and Babies
Born to Drug or Alcohol Abusing/Addicted Mothers

Name of Infant: _____
Time & date of referral: _____
Name of referring hospital: _____
Time & date hospital contacted after initial referral: _____
Time & date infant discharged from hospital: _____
Time & date of home visits: pre-discharge _____
post-discharge _____
Disposition of referral: _____
_____

District _____ Date _____

Referral Log

Drug or Alcohol Involved Newborns and Babies
Born to Drug or Alcohol Abusing/Addicted Mothers

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Time & date hospital contacted after initial referral: _____
Time & date infant discharged from hospital: _____
Time & date of home visits: pre-discharge _____
post-discharge _____
Disposition of referral: _____
_____

REFERRALS TO VOLUNTARY FAMILY SERVICES OF
DRUG OR ALCOHOL INVOLVED NEWBORNS AND
BABIES BORN TO DRUG OR ALCOHOL ADDICTED OR ABUSING MOTHERS

Effective March 9, 1987, the Secretary established a policy to handle reports from public and private hospitals of drug or alcohol addicted newborns and babies born to mothers who are addicted to or abusing drugs or alcohol. Initial response to these reports is made by county public health nurses who will make referrals for appropriate services, including Voluntary Family Services (VFS). The policy calls for a referral to Voluntary Family Services (VFS) if there is a potential of child abuse or neglect in the family but if it is not known or suspected to have already occurred.

Voluntary Family Services is a voluntary program which directs its activities toward helping dysfunctional or disorganized families with a potential for abuse or neglect of their children. Voluntary Family Services has no investigative authority or responsibility. The family must agree to accept Voluntary Family Services involvement. Voluntary Family Services will provide short-term intervention (three to six months).

The professional referring a family to Voluntary Family Services that has been identified as being in need of services due to drug or alcohol newborns should have no specific allegations of abuse or neglect but has concerns about the child/rens safety and welfare based on first hand observations. Any specific allegation of abuse or neglect should be reported to Intake.

Voluntary Family Services Counselors would be available to visit the family as often as necessary to provide the following services:

- Counseling in these areas - parenting, improving relationships between parents and children and between children themselves, housekeeping responsibilities, proper home maintenance, budget management, and meal preparation.

- Counseling about and arrangements for needed medical, psychological and psychiatric evaluation and treatment.

- Help with arranging transportation to appointments and referrals to other local agencies with programs that may help with any emergency needs.

- Referrals are also made to any Health and Rehabilitative Services or other State, local or federal programs that offer services or benefits for which these families may be eligible.

REPORT TO THE HOUSE SELECT COMMITTEE

ON

NARCOTICS ABUSE AND CONTROL

Presented By: Patricia O. Neibel
Executive Director
Child Protection Team
of
Broward County, Inc.

child protection team
OF BROWARD COUNTY, INC.

Broward General Medical Center
1600 South Andrews Avenue
Fort Lauderdale, Florida 33316
305-463-3131
Ext. 1217

The following is an excerpt from a letter dated August 12, 1987 regarding a second referral on a child.

I found the burns to his right thigh and right abdomen, from a curling iron, completely healed. However, I feel that this child is being neglected and that this home environment is a potentially dangerous one.

Child was sleeping in a bed with his sister, cousin, and his mother when I arrived. He was very dirty. His nailbeds and feet had crusted dirt on them. His diaper was saturated with urine and stool. His mother stated she tried to bathe him daily. His diaper area was excoriated from a rash as well.

I found broken bottles and glass at the front entrance and kitchen areas. The pathways in the apartment were blocked with piles of clothing and garbage. The bathroom was out of service and could not be entered due to the enormous pile of dirty clothing in it. There was no other bathroom in the apartment.

In the kitchen I found possible evidence of crack cocaine use. The countertops had numerous burnt out areas, candles, matches, ashes, and burnt paper towels lying about. I did not find any evidence of food in the kitchen refrigerator. Mother stated she fed the child rice to keep his belly full.

Program funded by the Florida Department of Health and Rehabilitative Services/Children's Medical Services

This child is two years old. He was:

1. Burnt with a curling iron seriously enough to be hospitalized
2. Not fed properly
3. Is walking on garbage and broken glass
4. Has no supervision - mother stoned

I. What kind of people abuse their babies:

1. torturers
2. people with no impulse control
3. people who lose control for 4 seconds
4. poor innocents who have no idea of the responsibilities of parenting

Cocaine users primarily fall into the second and third categories.

Let me explain about Child Protection Team. We assess whether a caretaker abused a child, or there was an accident. Unlike HRS whose interest is to protect the family, our only concern is the safety and well being of the child. The most difficult cases are the only ones we take.

1. child hospitalized due to abuse
2. siblings of child who dies as result of abuse
3. non ambulatory children
4. children under the age of 4
5. those other cases on which HRS requests our help

The Child Protection Team is comprised of:

-Board Certified Pediatricians
-Clinical Psychologist, formerly head of University of Miami Department of Child Psychology
-PhD Psychiatric Social Worker
-Masters in Psychology
-Masters in Child Development
-Registered Nurse

Our role is to give the Court a medical and psychosocial evaluation and recommend a proper agency to give the entire family support.

Possible recommendations are:

a. child may be removed
b. force the mother to attend drug therapy courses

c. put them under HRS Voluntary Family Services "unexpected visitors"
d. attempt to educate the parent to put her priorities in order - to care for her child in a protective manner

In the last six years our referrals increased from 200 cases per year to over 2,000. Fortunately, some of these cases were proven to be accidents.

We have not kept statistics on the use of cocaine by a caretaker. Informally, we polled our cases over the past two months. In 70% of the cases one or the other parent was a substance abuser, between 25% and 40% used cocaine.

Children of cocaine users are at greater risk because their mother's sense of reality is distorted. The user's prime concern is supporting her habit. Her mental processes are affected and she can't make good decisions. As the addiction increases, so does the risk to her child. The most common problem we encounter is neglect.

A child is:
1. deprived of food and adequate shelter
2. deprived of medical care
3. ignored - emotional abuse, resulting in a lack of bonding

III. What can we do to prevent children from growing up in such a sordid environment? We can decriminalize cocaine addiction as we have done with alcohol addiction. They are both diseases. We have years of experience treating and rehabilitating alcoholics. Let us do the same for the cocaine users. The pushers and drug dealers should continue to be sought out and prosecuted. I do not mean to be lax on them.

PREVENTION - EDUCATION

The national TV project using spots of famous entertainers saying Cocaine Isn't Cool is excellent. It should increase and multiply. Also, it should include a tag line listing crisis lines in that individual community.

We can also use the scripts of the soap operas, the prime time TV programs such as Magnum, Dallas, Murder She Wrote, and Family Ties to educate families to spot specific symptoms of addiction and the strategic way families can deal with the abuser. There are methods of intervention that families need to know.

Mothers don't want to hurt their babies - either before or after birth. Good prenatal care including support in kicking the habit will help some of them.

We had a couple who came in because of neglect of their child. When she had been pregnant the mother had been able to give up drugs at the father's insistence but couldn't give up alcohol. The result was a badly deformed alcohol syndrome baby. With professional help who knows?

The State of Maine was successful in an intensive TV campaign on prenatal care, offering a free baby magazine subscription. The magazine had articles on nutrition, shaken baby syndrome, and listed good prenatal clinics for those eligible for them. We could do the same, adding a component on cocaine and other substance abuse.

AFTER THE FACT - The Birth of a "Cocaine Baby"

If the Health Department's surveillance is not enough to keep the baby safe, there must be intervention. Why not a "mother-child" in-house facility. Gradually, the mother could assume the care of her baby. She would be taught parenting skills. She would learn about its physical needs and its emotional ones. When discharged, the mother would be better prepared to care for her baby and, most important, has bonded with her. Is it cost effective? Certainly. It is cheaper to put them both in one facility rather than the mother in treatment and the child in foster care.

A functioning imperfect parent is far better than the best of foster care. Perhaps we would have to make monthly visits and/or put the child in day care until school age. We don't want to see a large segment of our children separated from their parents. We must help the parents to function - and if necessary, watch to see that they do function.

The Child Protection Team's concern is for the safety and well-being of the child. I have addressed the education and treatment of the mother, not for her sake, but because the child has a right to be safe and protected.

BROWARD COUNTY ALCOHOL AND DRUG ABUSE SERVICES DIVISION

OUTREACH TREATMENT FOR PARENTS OF COCAINE BABIES

SUBMITTED BY: RUTHER CARTER, MS, CAC

The Broward County Commission's Alcohol and Drug Abuse Service Division assists individuals and their families with alcohol and drug-related problems through a wide variety of programs. The Division operates the Broward Addiction Rehabilitation Center, 1000 S.W. Second Street, Fort Lauderdale, at which it offers detoxification, diagnosis and assessment, intensive residential therapy, outpatient and outreach services.

OUTREACH SERVICES

The addicted mothers seeking help will be served under the Outreach Program at BARC. The Outreach Program is the arm of BARC that reaches into low income and minority communities for the purpose of identifying persons in need of services, alerting persons and their families to the availability of the services, locating needed services and enabling persons to enter and accept the services delivery system. This unit operates out of BARC's main facility and neighborhood multi-purpose centers within the cities of Hallandale, Hollywood, Dania, Fort Lauderdale, and Deerfield Beach.

The community demand for services has focused on a population most effectively served through the Outreach Program. The target population are those mothers who cannot effectively participate in the Substance Abuse Programs in the main location because of geographical distance and the need for extra motivation or educational information.

In order to highlight this demand the following are statistics developed before a program was funded or staffed. These clients have been added to an already over-burdened case load.

Statistics prior to funding:

Referals and walk-ins for services, November 1986, to October 10, 1987. TOTAL - 146.

Intervention:

Came for treatment during pregnancy:	32
Total drop-out treatment within 30 days:	57
Total active in treatment:	25
Total completed 90 days in treatment:	55
Total contacts for information only:	210

Age Group		Racial	
Under 17	2	Black	126
18-22	67	White	19
23-30	66	Spanish	1
31-35	8	Others	0
36-40	3		

Funding:

Effective November 1, 1987, the County will receive $100,000 from The Florida State Department of Health and Rehabilitative Services, Children, Youth and Family Division to staff this project and to provide some minimal funds to purchase housing and child care.

SERVICES

Clients who contact the agency directly or are referred by Broward General Medical Center, Broward County Public Health Unit, Visiting Nurse Association, etc., BARC will complete an initial assessment including:

1) Psychosocial evaluations on mother
2) Treatment recommendations
3) Provision of treatment and/or referrals
4) Home visits as necessary with health unit nurses or other social or health agency.

An individual long and short-term treatment plan is negotiated with each client.

Individual client therapy sessions are held according to the needs of the client.

Outpatient sessions are held in the home when necessary.

Clients are referred into group therapy as soon as it is clinically appropriate.

- Regular groups are offered to clients. Group content consists of family issues, life management skills, substance abuse education, and early abstinence issues and pregnancy issues.

Eligibility Criteria:

1. Substance abusing mothers referred pre-natally through the HRS Broward County Public Health Unit.

Eligibility Criteria (cont'd):

2. Drug abusing mothers who appear motivated to establish a drug free life style in a less restrictive environment than a residential setting.

3. Mothers who have delivered babies in the last 24 hours whose babies were born addicted.

4. Mothers who are abusing alcohol or drugs and call in or walk into the BARC system for help.

5. Families who are seeking services for a cocaine abusing pregnant mother.

6. Substance abusing clients who are involved in pre-natal care.

Summary:

This program is designed to help dysfunctional mothers and expectant mothers with a potential for abuse or neglect of their children due to drug abuse.

In order to address this issue effectively there must be new legislation which will insure that these clients are identified and mandated into treatment. The present law does not permit intervention for these addicted mothers. The State of Florida Health and Rehabilitative Services (HRS) Youth and Family Services C.Y.F. intake does not intervene until there is indication of abuse or neglect. At present, we utilize the Pre-protective Services Unit which is a voluntary program designed to help dysfunctional family with potential for abuse or neglect of their children. This unit has no investigative authority or ability to enforce a client's involvement in treatment and therefore, is ineffective in providing the support necessary to motivate those clients into rehabilitative services.

The new policy effective March 9, 1987, of the Office of Program Policy Development of the State of Florida Department of Health and Rehabilitative Services (HRS) mandates that hospitals refer drug or alcohol involved newborns and addicted or abusing mothers to the Public Health Programs Office. They will act as the Case Manager and will make referrals for services as needed.

Problems:

1. Lack of residential treatment for cocaine abusing mothers after childbirth and pregnant mothers who are living in the street.

2. Lack of any law to force cocaine abusing pregnant women to treatment.

3. Lack of legal protection for babies born to cocaine mothers who continue to abuse cocaine after childbirth.

Recommendations:

1. Increase federal funds to provide residential care and companion child care services for cocaine abusing mothers and their children.

2. Mothers diagnosed during pregnancy or after with a trace of any illegal or unprescribed chemical should be court-ordered into treatment for a minimum of ninety (90) days to six (6) months and the newborn baby placed under the care of protective service.

3. The law should require drug testing whenever pre-natal care is provided. This law should include all Public and Private Agencies.

STATEMENT OF JOSEPH H. DEATSCH, M.D.

CHAIRMAN, COMMITTEE ON SUBSTANCE ABUSE

FLORIDA MEDICAL ASSOCIATION, INC.

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

FORT LAUDERDALE, FLA. OCTOBER 16, 1987

MISTER CHAIRMAN AND MEMBERS OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL:

MY NAME IS DOCTOR JOSEPH H. DEATSCH OF JACKSONVILLE, FLORIDA. I AM A MEDICAL DOCTOR, AND IN MEDICAL CIRCLES I AM WHAT IS KNOWN AS AN ADDICTIONOLOGIST. MY PRACTICE IS LIMITED TO THE TREATMENT OF CHEMICAL ADDICTION. DURING THE COURSE OF MY WORK I TREAT PATIENTS WHO ARE ADDICTED TO MANY DIFFERENT DRUGS . . . PRESCRIPTION MEDICINES, HEROIN, COCAINE AND OTHERS.

I APPEAR BEFORE YOU TODAY IN MY ROLE AS CHAIRMAN OF THE COMMITTEE ON SUBSTANCE ABUSE OF THE FLORIDA MEDICAL ASSOCIATION, TO WHICH THE MAJORITY OF MEDICAL DOCTORS IN FLORIDA BELONG. I HAVE HELD THIS POSITION FOR ABOUT THREE YEARS, ALTHOUGH MY INTEREST IN SUBSTANCE ABUSE PREDATES MY WORK WITH THIS COMMITTEE.

AS A FLORIDIAN AND AS A PHYSICIAN I AM VERY MUCH AWARE THAT DRUG ABUSE AND DRUG ADDICTION AND ALL THEIR SOCIAL RAMIFICATIONS HAVE BECOME A MAJOR PROBLEM IN THIS STATE. THE REALITY OF THIS IS EPITOMIZED BY THE FACT THAT A MAJOR COCAINE TRAFFICKING TRIAL IS UNDER WAY IN JACKSONVILLE, FLORIDA, AT THE PRESENT TIME.

I KNOW THAT THIS COMMITTEE AT THIS HEARING IS INTERESTED PARTICULARLY IN INFORMATION REGARDING COCAINE, PARTICULARLY AS IT EFFECTS PREGNANT WOMEN AND THEIR UNBORN OR NEWBORN CHILDREN. I WILL GET INTO THAT, BUT FIRST THERE ARE TWO PROPOSITIONS I WISH TO SUBMIT TO YOU. I THINK THEY ARE IMPORTANT AND SHOULD BE KEPT IN MIND AS WE ADDRESS THE COCAINE CRISIS.

THE FIRST PROPOSITION IS THAT ALL OF OUR EFFORTS WITH REGARD TO COCAINE SHOULD BE CARRIED OUT IN THE CONTEXT OF A BROADER PICTURE THAT WE MIGHT SIMPLY CALL DRUG ABUSE OR CHEMICAL ADDICTION. MANY OF THE PRINCIPLES OF COMBATTING COCAINE ALSO APPLY TO OTHER TYPES AND CLASSES OF BOTH LEGAL AND ILLICIT DRUGS.

THERE ONCE WAS A TIME WHEN MARIJUANA WAS OUR MAJOR DRUG PROBLEM. AT ANOTHER TIME HEROIN WAS IN VOGUE. SEVERAL YEARS AGO WE HEARD MORE ABOUT L-S-D THAN ANYTHING ELSE. TODAY, THE DRUG JUST HAPPENS TO BE COCAINE IN ITS VARIOUS FORMS.

IT WOULD BE NICE IF OVERNIGHT WE COULD SOLVE OUR COCAINE PROBLEM COMPLETELY . . . DRY UP THE SUPPLY AND GET ALL THE UNFORTUNATE ADDICTS TREATED AND REHABILITATED. EVEN IF WE COULD BE SO SUCCESSFUL, I CAN ASSURE YOU THERE WOULD BE ANOTHER DRUG ON THE STREET TO TAKE ITS PLACE THE NEXT DAY.

THAT'S WHY I SAY WE NEED TO TAKE A MORE PANORAMIC VIEW OF OUR DRUG PROBLEM. WE CERTAINLY NEED TO DIRECT MAJOR EFFORTS AGAINST COCAINE, BUT AT THE SAME TIME WE MUST KEEP IN MIND THERE ARE MANY OTHER DRUGS OUT THERE.

THE SECOND THING I THINK WE SHOULD REALIZE IS THAT NO ONE PERSON . . . NO ONE ORGANIZATION--NOT THE CONGRESS AND NOT THE FLORIDA MEDICAL ASSOCIATION--IS GOING TO SINGLE-HANDEDLY PUT AN END TO THE COCAINE PROBLEM OR ANY OTHER DRUG-RELATED CRISIS.

THE PROBLEM IS SIMPLY TOO BIG FOR UNILATERAL APPROACHES. THE HEALTH CARE DELIVERY SYSTEM, THE CRIMINAL JUSTICE SYSTEM, FAMILY RELATIONSHIPS AND MANY OTHER FACETS OF OUR SOCIETY ARE NOT ONLY AFFECTED BUT HEAVILY BURDENED.

THE ANSWER TO THE PROBLEM. . . IF THERE IS AN ANSWER . . . PROBABLY WILL LIE IN THE SYNERGISM WHICH IS TYPICALLY INHERENT IN BROAD-BASED EFFORTS IN WHICH ALL INTERESTED GROUPS AND INDIVIDUALS PARTICIPATE AND COOPERATE. SO THE PROBLEM IS NOT MERELY ONE OF LAWMAKING AND TREATMENT, THE TWO ASPECTS THAT YOU AND I REPRESENT. IT IS ALSO THE BUSINESS OF PARENTS, OUR EDUCATIONAL SYSTEM; CHURCHES AND SYNAGOGUES; FRATERNAL ORGANIZATIONS, TRADE AND PROFESSIONAL ASSOCIATIONS; LABOR UNIONS; LAWYERS, JUDGES AND LAW ENFORCEMENT AGENCIES; PHARMACISTS; NEWSPAPERS, RADIO AND TELEVISION STATIONS; AND OTHERS.

IT WAS ON THAT BASIS THAT THE FLORIDA MEDICAL ASSOCIATION CONVENED FOR THE FIRST TIME SEVENTEEN (17) YEARS AGO AN AD HOC COMMITTEE ON DRUG ABUSE CONSISTING OF NOT ONLY PHYSICIANS BUT ALSO REPRESENTATIVES OF LAW ENFORCEMENT, PHARMACY, THE LEGAL PROFESSION AND OTHER INTERESTED GROUPS. IT WAS THIS COMMITTEE THAT EVENTUALLY EVOLVED INTO THE COMMITTEE WHICH I NOW CHAIR.

WHILE THE CURRENT COMMITTEE IS NOT AS MULTI-DISCIPLINARY IN CHARACTER AS IT WAS IN 1970, MOST OF WHAT WE, THE MEDICAL PROFESSION, DO IS CARRIED OUT IN COOPERATION WITH OTHER INTERESTED ORGANIZATIONS . . . GROUPS SUCH AS THE FLORIDA BAR, THE FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, THE FLORIDA INFORMED PARENTS, THE FLORIDA COCAINE TASK FORCE, AND OTHERS.

EARLIER THIS YEAR, THE FLORIDA MEDICAL ASSOCIATION JOINED WITH THE FLORIDA BAR AND THE FLORIDA INFORMED PARENTS ORGANIZATION IN A PROJECT AIMED AT MAKING PARENTS MORE AWARE OF THE MEDICAL AND LEGAL ASPECTS OF ALCOHOL AND DRUG ABUSE. THE CORNERSTONE OF THIS PROGRAM IS A SPEAKERS BUREAU CONSISTING OF DOCTOR-LAWYER TEAMS WHO SPEAK TO PARENT, CHURCH AND CIVIC GROUPS ABOUT TEENAGE SUBSTANCE ABUSE, THE CONSEQUENCES AND PARENTAL CONCERNS. THE PROGRAM ALSO INCLUDED PRODUCTION OF PUBLIC SERVICE ANNOUNCEMENTS WHICH HAVE BEEN AIRED ON FLORIDA RADIO AND TELEVISION STATIONS.

IN THE EARLY 1980'S, THE FLORIDA MEDICAL ASSOCIATION AND OTHER INTERESTED PARTIES CAME TOGETHER TO FORM ONE OF THE VERY FIRST "PADS" PROGRAMS IN THE COUNTRY. "PADS" STANDS FOR "PRESCRIPTION ABUSE DATA SYNTHESIS PROJECT". THE CONCEPT OF PADS ORIGINATED WITH THE INFORMAL STEERING COMMITTEE ON PRESCRIPTION DRUG ABUSE WHICH HAD BEEN ASSEMBLED BY THE AMERICAN MEDICAL ASSOCIATION AND IN WHICH I ALSO PERSONALLY PARTICIPATED.

THE PURPOSE OF "PADS" IS TO BRING THE FORCES AND RESOURCES OF VARIOUS INTERESTED PARTIES TO BEAR ON THE PROBLEM OF PRESCRIPTION DRUG ABUSE, MISUSE AND DIVERSION. IN THIS PROJECT WE HAVE BEEN WORKING WITH SUCH STATE AGENCIES AS THE MEDICAID OFFICE, THE DEPARTMENT OF PROFESSIONAL REGULATION, THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, THE ATTORNEY GENERAL'S OFFICE AND THE FLORIDA DEPARTMENT OF LAW ENFORCEMENT . . . OTHER STATE PROFESSIONAL GROUPS SUCH AS THE PHARMACISTS, THE NURSES AND THE OSTEOPATHS, THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION, INFORMED PARENTS AND OTHER ORGANIZATIONS.

THE FLORIDA MEDICAL ASSOCIATION'S INVOLVEMENT WITH THE GOVERNOR'S COMMISSION ON ALCOHOL AND DRUG CONCERNS, WHICH FORMER GOVERNOR BOB GRAHAM APPOINTED IN 1985, WAS ANOTHER EXAMPLE OF ORGANIZATIONS AND PEOPLE WORKING TOGETHER ON A PROBLEM.

FROM LAST NOVEMBER INTO FEBRUARY OF THIS YEAR, THE FLORIDA MEDICAL ASSOCIATION SPONSORED AN ANTI-DRUG OUTDOOR ADVERTISING CAMPAIGN IN COOPERATION WITH EIGHT OF ITS COUNTY MEDICAL SOCIETIES. A TOTAL OF ONE HUNDRED EIGHTY-THREE (183) BILLBOARDS BEARING THE MESSAGE "SAY 'NO' TO ILLEGAL DRUGS" WERE DISPLAYED IN ALACHUA, DUVAL, HILLSBOROUGH, ORANGE, PALM BEACH, PINELLAS, POLK AND SEMINOLE COUNTIES. THE ESTIMATED DAILY EXPOSURE WAS TWO MILLION SIX HUNDRED THIRTY-FIVE THOUSAND (2,635,000).

MOST COUNTY MEDICAL SOCIETIES, OF WHICH THERE ARE 47 IN FLORIDA, HAVE SPEAKERS BUREAUS WHICH FURNISH SPEAKERS ON A VARIETY OF SUBJECTS, INCLUDING SUBSTANCE ABUSE TO VARIOUS LAY GROUPS. UNFORTUNATELY, SINCE THERE IS NO CENTRAL SOURCE OF INFORMATION ON THIS, I CANNOT TELL YOU HOW MANY SUCH PRESENTATIONS HAVE BEEN MADE.

THE COMMITTEE SHOULD ALSO KNOW THAT THE FLORIDA MEDICAL ASSOCIATION HAS A PROGRAM TO IDENTIFY, TREAT AND REHABILITATE PHYSICIANS WHOSE ABILITY TO PRACTICE MEDICINE IS IMPAIRED BY ALCOHOLISM AND OTHER ADDICTIONS. FOR THE PAST TWO AND ONE-HALF YEARS THE FLORIDA MEDICAL ASSOCIATION HAS HAD A FULLTIME MEDICAL DIRECTOR FOR THIS PROGRAM ON THE PAYROLL. WITHIN THE PAST FEW MONTHS OUR IMPAIRED PHYSICIANS PROGRAM HAS CONTRACTED WITH THE STATE DEPARTMENT OF PROFESSIONAL REGULATION TO PROVIDE

SIMILAR SERVICES TO OTHER LICENSED HEALTH CARE PROFESSIONALS SUCH AS PODIATRISTS, OSTEOPATHS AND PHARMACISTS.

MOST OF THE F-M-A'S DRUG ABUSE-RELATED ACTIVITIES I HAVE DESCRIBED SO FAR ARE RATHER GENERAL IN NATURE. FLORIDA PHYSICIANS ARE, OF COURSE, PARTICULARLY CONCERNED ABOUT COCAINE. ACCORDINGLY, THE FLORIDA MEDICAL ASSOCIATION AND ITS AUXILIARY ARE ENTHUSIASTIC PARTICIPANTS IN THE WORK OF THE FLORIDA COCAINE TASK FORCE THAT WAS SET UP IN 1985.

LATE LAST YEAR, THE TASK FORCE ISSUED ITS REPORT CALLED "CRISIS IN OUR LAND". WE HAVE PROVIDED EACH MEMBER OF THE COMMITTEE WITH A COPY. IF YOU WILL LOOK AT PAGES EIGHT (8) THROUGH FOURTEEN (14) YOU WILL NOTE THAT THE TYPES OF PEOPLE WHO SERVE ON THE TASK FORCE, CONSULTED WITH IT, OR MADE PRESENTATIONS TO IT REPRESENT A BROAD SPECTRUM OF EXPERTISE AND INTEREST.

THERE ARE MANY, MANY SCIENTIFIC ARTICLES IN THE MEDICAL LITERATURE ABOUT COCAINE AND COMPONENT TOPICS. IN PREPARING FOR THIS PRESENTATION WE ASKED THE AMERICAN MEDICAL ASSOCIATION FOR ABSTRACTS OF SOME OF THE MAJOR ARTICLES ON COCAINE AND PREGNANCY THAT HAVE BEEN PUBLISHED WITHIN THE PAST FEW YEARS. WITHIN MINUTES WE HAD A COMPUTER-GENERATED DOCUMENT IN FRONT OF US (ATTACHMENT 1).

WE ALSO ASKED THE BORLAND MEDICAL LIBRARY IN JACKSONVILLE TO SCAN THE LITERATURE FOR THE PAST FIVE YEARS USING THE MEDLINE COMPUTER SYSTEM. ITS SEARCH IDENTIFIED 28 MAJOR ARTICLES. (ATTACHMENT 2).

MOST OF THESE ARTICLES WERE PUBLISHED IN JOURNALS THAT ARE KEPT IN VIRTUALLY EVERY HOSPITAL LIBRARY. IN THE CASE OF ARTICLES PUBLISHED IN LESS WIDELY CIRCULATED JOURNALS, REPRINTS CAN BE ACQUIRED IN A RELATIVELY SHORT TIME.

IN ADDITION TO SCIENTIFIC ARTICLES, THERE ARE COUNTLESS CONTINUING MEDICAL EDUCATION PROGRAMS OFFERED EACH YEAR. THE PRACTICING PHYSICIANS HAS PLENTY FROM WHICH TO PICK AND CHOOSE.

THE FLORIDA MEDICAL ASSOCIATION HAS DONE ITS PART IN HELPING TO EDUCATE PHYSICIANS ABOUT COCAINE. SINCE 1981, A SCIENTIFIC SESSION ON CHEMICAL DEPENDENCY HAS BEEN ARRANGED AS PART OF THE ANNUAL MEETINGS OF OUR ASSOCIATION. FOR EACH OF THE PAST FOUR YEARS, THIS PROGRAM HAS INCLUDED A MAJOR SEGMENT ON COCAINE.

THE FLORIDA MEDICAL ASSOCIATION IS IN THE PROCESS OF PUBLISHING A SMALL HANDBOOK ON COCAINE FOR DISTRIBUTION TO ALL LICENSED MEDICAL DOCTORS AND DOCTORS OF OSTEOPATHY IN FLORIDA, MEMBERS AND NONMEMBERS ALIKE. A PRE-PUBLICATION TEXT OF THIS WORK IS ATTACHED TO MY WRITTEN PRESENTATION (ATTACHMENT 3). NOTE THAT IT DOES CONTAIN A SECTION ON REPRODUCTIVE AND NEONATAL ASPECTS OF COCAINE USE.

WORKING THROUGH THE AMERICAN MEDICAL ASSOCIATION, WE PLAN TO APPLY TO THE NATIONAL INSTITUTE OF DRUG ABUSE FOR A PHYSICIAN EDUCATION GRANT. I CANNOT TELL YOU AT THIS TIME PRECISELY WHAT FORM THIS PROGRAM WILL TAKE, BUT IT MOST CERTAINLY WILL ENCOMPASS COCAINE.

THERE IS UNQUESTIONABLY AN ABUNDANCE OF SCIENTIFIC MATERIAL AND INFORMATION AVAILABLE TO FLORIDA PHYSICIANS ON COCAINE AND ITS IMPACT ON PREGNANT WOMEN AND THEIR CHILDREN. THERE IS NO WAY OF DETERMINING HOW AND TO WHAT EXTENT THIS INFORMATION IS ABSORBED AND USED. BUT IT IS MY PERCEPTION THAT FLORIDA PHYSICIANS IN GENERAL HAVE BECOME GENERALLY WELL INFORMED ON THIS SUBJECT SINCE IT IS ONE THAT STRIKES CLOSE TO HOME.

IT IS NOT REALISTIC TO EXPECT EVERY PHYSICIAN IN THIS STATE TO BE AN EXPERT IN TREATING COCAINE ADDICTION. BUT IT IS REASONABLE TO EXPECT THAT EACH PHYSICIAN CAN DEVELOP THE EXPERTISE TO PINPOINT THE ADDICT IN HIS PRACTICE AND TO REFER THAT INDIVIDUAL TO AN APPROPRIATE TREATMENT PROVIDER.

WE PHYSICIANS WHO SPECIALIZE IN THIS FIELD ARE CONCERNED ABOUT SUBSTANCE ABUSE EDUCATION AT THE MEDICAL SCHOOL LEVEL. WE WOULD LIKE TO SEE GREATER EMPHASIS AND GREATER IDENTITY PLACED ON WHAT IS BEING OFFERED AT THE PRESENT TIME. VERY OFTEN THE MEDICAL STUDENT GETS EXPOSURE TO THIS INFORMATION IN VARIOUS CLASSROOM AND CLINICAL ENCOUNTERS RATHER THAN IN ONE DEFINED AND STRUCTURED COURSE OR EXPERIENCE. AN EXAMPLE IS DESCRIBED IN A LETTER TO ME FROM DOCTOR WILLIAM B. DEAL, DEAN OF THE COLLEGE OF MEDICINE AT THE UNIVERSITY OF FLORIDA (ATTACHMENT 4). NOTE THAT AT THE UNIVERSITY OF FLORIDA SUBSTANCE ABUSE IS COVERED IN SIX DIFFERENT COURSES AND CLERKSHIPS.

AS ONE WHO SEES FIRST-HAND THE RAVAGES OF SUBSTANCE ABUSE ON A DAILY BASIS, I AM STRONGLY IN FAVOR OF MORE SUBSTANCE ABUSE EDUCATION IN OUR MEDICAL SCHOOLS AND IN OUR RESIDENCY TRAINING PROGRAMS AFTER MEDICAL SCHOOL. HOWEVER, THERE ARE PROBLEMS WITH BOTH TIME AND MONEY. ASK A MEDICAL SCHOOL DEAN TO PUT SOMETHING NEW INTO HIS ALREADY CROWDED CURRICULUM AND HE IS LIKELY TO ASK: "WHAT WOULD YOU HAVE TAKEN OUT OF THE CURRICULUM TO MAKE ROOM FOR IT?"

THE POINT IS LEGITIMATE. MEDICAL SCIENCE, EVEN IN JUST THE LAST FEW YEARS, HAS TAKEN DRAMATIC LEAPS FORWARD. THERE IS NO WAY THAT ALL OF THIS CAN BE INCORPORATED INTO THE STANDARD FOUR-YEAR MEDICAL SCHOOL SCHEDULE.

IT IS APPROPRIATE THAT THIS COMMITTEE IS CONDUCTING THIS PROCEEDING IN THIS PARTICULAR CITY AND THIS PARTICULAR HOSPITAL, FOR THIS AREA IS AMONG THOSE THAT HAVE EXPERIENCED THE COCAINE EPIDEMIC MOST ACUTELY. I UNDERSTAND THAT BROWARD GENERAL MEDICAL CENTER HAS AN EXCELLENT COCAINE REPORTING SYSTEM.

IN 1986, I AM TOLD, TEN (10) PER CENT OF THE BABIES BORN HERE HAD SOME CONNECTION WITH COCAINE. AND FORTY (40) PER CENT OF THE NEWBORN IN THE NEONATAL INTENSIVE CARE UNIT WERE SUFFERING FROM COCAINE-RELATED CONDITIONS.

NUMBERS LIKE THESE CAN REALLY OPEN EYES, AND I WOULD HOPE THAT SIMILAR REPORTING AND RECORD-KEEPING SYSTEMS COULD BE PUT IN PLACE THROUGHOUT FLORIDA.

IN CONCLUSION, I WANT TO ASSURE THIS COMMITTEE THAT COCAINE, OTHER DRUGS OF ABUSE AND THEIR DEVASTATING EFFECTS ON HUMAN LIFE ARE VERY MUCH ON THE MIND OF THE FLORIDA MEDICAL ASSOCIATION. AS INDIVIDUAL PHYSICIANS WE, ALONG WITH OTHER DISCIPLINES, ARE GENERALLY INVOLVED IN THE TREATMENT ASPECTS OF THIS PROBLEM. BUT AS AN ORGANIZATION, I SEE OUR PRIMARY ROLE AS ONE OF PREVENTION AND EDUCATION . . . EDUCATION OF NOT ONLY OUR OWN MEMBERS AND MEMBERS OF THE OTHER HEALTH CARE PROFESSIONS, BUT THE LAY PUBLIC AS WELL.

WE WILL NOT SHRINK FROM THAT RESPONSIBILITY.

ON BEHALF OF THE FLORIDA MEDICAL ASSOCIATION I WISH TO THANK THE COMMITTEE FOR THIS OPPORTUNITY TO VISIT AND SHARE OUR THOUGHTS.

#

Attachment 1

AMA LITERATURE SEARCH

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      274      2      cocaine
     8716      3      pregnancy
        4      4      1 and 2 and 3

Your search retrieved 4 documents.
Do you want to see these document titles? (YES) )


Set number 4 contains 4 documents

1       Medical complications of cocaine abuse
2       Pharmacologic effects on labor: Effects of drugs on dystocia, labor,
        and uterine activity
3       Effect of cocaine on uterine blood flow and fetal oxygenation
4       Decreased incidence of intraventricular hemorrhage in infants of
        opiate dependent mothers

Enter selection number(s), MORE to see more titles or
BACK/STOP/BYE/OFF (STOP) ) more


No more titles to display

Do you want to perform another search? (YES))

Your search retrieved 12 documents.
Do you want to see these document titles? (YES) )


Set number 3 contains 12 documents

1       Medical complications of cocaine abuse
2       Pharmacologic effects on labor: Effects of drugs on dystocia, labor,
        and uterine activity
3       Effect of cocaine on uterine blood flow and fetal oxygenation
4       Decreased incidence of intraventricular hemorrhage in infants of
        opiate dependent mothers
5       Ocular signs of cocaine intoxication in neonates
6       Occurrence of strabismus in infants born to drug-dependent women
7       Teratogenicity of cocaine in humans
8       Perinatal cerebral infarction and maternal cocaine
9       The consequences in young adulthood of adolescent drug involvement
10      Peripheral nerve conduction studies in passively addicted neonates
11      Maternal cocaine abuse and effect on the newborn
12      Cocaine use in pregnancy

Enter selection number(s), MORE to see more titles or
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Item 1

Document 87119220
Title Medical complications of cocaine abuse
Author Cregler L.L.; Mark H.;
Source 1986 315/23 (1495-1500) NEJMA New England Journal of Medicine

No abstract is available for this document

Continue? YES/NO/ALL/ORDER/HELP (YES)) yes

Item 2

Document 87118619
Title Pharmacologic effects on labor: Effects of drugs on dystocia, labor, and uterine activity
Author Baxi L.V.; Petrie R.H.;
Source 1987 30/1 (19-32) COGYA Clinical Obstetrics and Gynecology

No abstract is available for this document

Continue? YES/NO/ALL/ORDER/HELP (YES))

Item 3

Document 87091890
Title Effect of cocaine on uterine blood flow and fetal oxygenation
Author Woods J.R. Jr.; Plessinger M.A.; Clark K.E.;
Source 1987 257/7 (957-961) JAMAA Journal of the American Medical Association

Five pregnant ewes and their singleton fetuses were instrumented at 115 to 120 days' gestation (term, 145 days) for heart rate, blood
** pressure, uterine blood flow, and arterial blood gas sampling. In
** separate studies, cocaine was given to the ewe or fetus as a 0.5-,
** 1.0-, or 2.0-mg/kg intravenous bolus, and cardiovascular and arterial
** blood gas values were obtained for 60 minutes after the injection. The
** results showed that maternal administration of cocaine produced
** dose-dependent increases in maternal blood pressure and decreases in
** uterine blood flow. Uterine vascular resistance increased by 52%, 96%, and 168%, respectively. These responses were accompanied by marked
** fetal hypoxemia, hypertension, and tachycardia. Direct cocaine
** administration to the fetus produced smaller increases in fetal heart
** rate and blood pressure than those observed following maternal cocaine
** injection, and no significant changes in fetal arterial blood gas
** values. The conclusions are (1) cocaine alters fetal oxygenation by
** reducing uterine blood flow and impairing oxygen transfer to the

** fetus; and (2) fetal cardiovascular changes to maternal administration
** of cocaine may reflect fetal hypoxemia, increased fetal levels of
** cocaine or fetal catecholamines, or a combination of these events.
**
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Continue? YES/NO/ALL/ORDER/HELP (YES))

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Item 4

Document 87088455
Title Decreased incidence of intraventricular hemorrhage in infants of opiate dependent mothers
Author Cepeda E.E.; Lee M.I.; Mehdizadeh B.;
Source 1987 76/1 (16-18) APSVA Acta Paediatrica Scandinavica
The incidence of intraventricular hemorrhage (IVH) in infants born to opiate dependent mothers was compared to infants whose mothers denied the use of addicting substances. The two groups were comparable in birth weight, gestational age, 1 and 5 min Apgar scores, and sex distribution. The incidence of breech presentations, PROM, and type of anesthesia at delivery were similar. However, more infants in the control group were delivered by cesarean section. The incidence of IVH was 52% in the controls and 23% in the opiate infants (p [0.05). Neonatal risk factors such as use of ventilators, incidence of pneumothorax, administration of pressor and sedative drugs, acidosis, use of alkali therapy and volume expanders, fluid therapy in the first three days and transfers to other hospitals were the same.

Continue? YES/NO/ALL/ORDER/HELP (YES))
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Item 5

Document 87072987
Title Ocular signs of cocaine intoxication in neonates
Author Isenberg S.J.; Spierer A.; Inkelis S.H.;
Source 1987 103/2 (211-214) AJOPA American Journal of Ophthalmology
**We examined 13 cocaine-intoxicated neonates, proven by urine assay, by
** slit lamp and found that most had iris blood vessel abnormalities.
** Using an iris vascularity scale that ranged from Grade 0 with no
** visible vessels to Grade 4 with dilated and tortuous vessels, we found
** that the intoxicated infants had increased grades in the iris
** periphery and collarette (P[.02) as compared to 36 control newborns
** who had no cocaine in their urine. Infants with dilated or tortuous
** iris vessels were more likely to be intoxicated by cocaine (P[.01).
** The presence of dilated or tortuous iris vessels in a neonate should
** signal the physician to rule out cocaine intoxication.
**
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Continue? YES/NO/ALL/ORDER/HELP (YES))

Item 6

Document 87070052
Title Occurrence of strabismus in infants born to drug-dependent women
Author Nelson L.B.; Ehrlich S.; Calhoun J.H.; et al.;
Source 1987 141/2 (175-178) AJDCA American Journal of Diseases of Children
**Maternal drug abuse during pregnancy exposes the fetus to the
** possibility of toxic or addicting effects. At a methadone hydrochloride maintenance program providing medical care to drug-dependent women and their infants, ophthalmologic examinations of all infants born during a 36-month period were performed. Twenty-nine infants prenatally exposed to psychoactive drugs were seen at birth and on follow-up. The 24% prevalence of strabismus found in the

** 5.3% reported in the general population. These data suggest that
** maternal drug abuse and increased methadone dosage during pregnancy
** may predispose infants to the development of strabismus.
**
End of document reached

Continue? YES/NO/ALL/ORDER/HELP (YES))

Item 7

Document 87043746
Title Teratogenicity of cocaine in humans
Author Bingol N.; Fuchs M.; Diaz V.; et al.;
Source 1987 110/1 (93-96) JOPDA Journal of Pediatrics
**To study teratogenicity of cocaine in humans, we studied three groups
** of pregnant women and their offspring: group 1, 50 women who abused
** cocaine only; group 2, 110 women who were polydrug abusers; and group
** 3, 340 who were drug free. All three groups were similar for
socioeconomic status, cigarette smoking, and ethnicity. Maternal age
of group 1 was similar to that of group 3, but group 2 mothers were
significantly older. Gravidity was significantly higher in groups 1
and 2 compared with group 3. No statistical difference was found in
spontaneous abortion rate among the three groups, but the stillbirth
rate was significantly higher in group 1 (chisup 2 = 6.89, P [or =
0.01). All stillbirths were related to abruptio placentae. Birth
weight, length, and head circumference were significantly decreased in
infants in groups 1 and 2 compared with group 3 (P [or = 0.0001), but
no statistical difference was found between groups 1 and 2. The
congenital malformation rate was significantly higher in group 1
** compared with group 3 (chisup 2 = 7.07, P [or = 0.01). We conclude
** that cocaine abuse in humans significantly reduces weight of the
** fetus, increases the stillbirth rate r
** fetus, increases the stillbirth rate related to abruptio placentae,
** and is associated with a higher malformation rate.
**
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Continue? YES/NO/ALL/ORDER/HELP (YES))

Item 8

Document 86115034
Title Perinatal cerebral infarction and maternal cocaine
Author Chasnoff I.J.; Bussey M.E.; Savich R.; Stack C.M.;
Source 1986 108/3 (456-459) JOPDA Journal of Pediatrics
**The use of cocaine as a recreational drug has increased markedly in the
** United States in the last few years. Concomitantly, more women have
** used cocaine during pregnancy. Information on the effects of cocaine
** on the developing fetus, however, is sparse. We report an infant who
** developed cerebral infarction after delivery at term to a women who
** used a large amount of cocaine in the 72 hours before delivery.
**
End of document reached

Continue? YES/NO/ALL/ORDER/HELP (YES))

Document 86204220
Title The consequences in young adulthood of adolescent drug involvement
Author Kandel D.B.; Davies M.; Karus D.; Yamaguchi K.;
Source 1986 43/8 (746-754) ARGPA Archives of General Psychiatry
To examine the consequences of adolescent drug use on the psychosocial

and women from age 15 or 16 years to age 25 years. The use of four different classes of drugs was examined: cigarettes, alcohol, marijuana, and other illicit drugs. Twenty outcomes were examined, including continuity of participation in work and in family roles, level of education, delinquent activities, self-reported health and psychological symptoms, and use of five drug classes in early adulthood (including prescribed psychoactive medications). The effects of marijuana and of other illicit drugs could not be disentangled, so these drugs were treated as a single class. Controlling for initial individual differences in adolescence, use of the three major drug classes between adolescence and early adulthood affected most of the outcomes examined; most strongly continued use of the same substance. Unique drug effects included those of illicit drugs on increased delinquency, unemployment, divorce, and abortions, and of cigarettes on lowered psychological mood. Illicit drugs predicted drug-related health problems, whereas cigarette use predicted increased breathing difficulties.

Document 86098698
Title Peripheral nerve conduction studies in passively addicted neonates
Author Doberczak T.M.; Kandall S.R.; Rongkapan O.; et al.;
Source 1986 67/1 (4-6) APMHA Archives of Physical Medicine and Rehabilitation

Neurologic signs dominate the manifestations of the neonatal abstinence syndrome (NAS). To help delineate this dysfunction, peripheral nerve conduction studies (NCS) were made in 25 neonates born to methadone-maintained mothers; 12 of the mothers abused other controlled substances concomitantly. Median and common peroneal motor nerve conduction velocities (NCV) in these infants were normal, both at three to seven days and three to four weeks of age, and were unaffected by maternal drug intake pattern, severity of neonatal abstinence symptoms, treatment with either camphorated tincture of opium or phenobarbital, intrauterine growth retardation, or abstinence-associated seizures. Electromyographic findings were normal in 21/23 infants; two others showed minimal partial denervation, characterized by fibrillations and positive sharp waves. NCV in the NAS may enhance gestational age assessment and therefore increase validity of neurobehavioral follow-up. Our studies continue to point to a central rather than a peripheral motor dysfunction exhibited by passively addicted infants at birth, which may persist on two-to-five year follow-up.

Item 11

Document 86066932
Title Maternal cocaine abuse and effect on the newborn
Author Madden J.D.; Payne T.F.; Miller S.;
Source 1986 77/2 (209-211) PEDIA Pediatrics

**Cocaine has been increasingly available to a wider population of
** potential users in the United States. Information concerning possible
** effects of this agent on the fetus and newborn is lacking. We observed
** eight infants whose mother's gave a history of cocaine abuse and, in
** whom, results of a urine screen for cocaine were positive. We observed no evident symptomatology or signs of teratogenicity on these infants. Although this is encouraging, more studies, including Brazelton assessment, and long-term follow-up of infants born to cocaine-abusing mothers is necessary.
End of document reached

Continue? YES/NO/ALL/ORDER/HELP (YES))

Item 12

Document 85237637
Title Cocaine use in pregnancy
Author Chasnoff I.J.; Burns W.J.; Schnoll S.H.; Burns K.A.;
Source 1985 313/11 (666-669) NEJMA New England Journal of Medicine
**With the increasing use of cocaine in the United States, there has been
** growing concern regarding its effects on the fetuses and neonates of
** pregnant cocaine abusers. Twenty-three cocaine-using women enrolled in
** a comprehensive perinatal-addiction program were divided into two
** groups: those using cocaine only and those using cocaine plus
** narcotics. These two groups were compared with a group of women who
** had used narcotics in the past and were maintained on methadone during
** pregnancy, and with a group of drug-free women. All four groups were
similar in maternal age, socioeconomic status, number of pregnancies,
and cigarette, marijuana, and alcohol use. Their medical histories
indicated that the cocaine-using women had a significantly higher rate
** of spontaneous abortion than the women in the other two groups. In the
** pregnancies under study, four cocaine-using women had onset of labor
** with abruptio placentae immediately after intravenous self-injection
** of cocaine. Neonatal gestational age, birth weight, length, and head
** circumference were not affected by cocaine use. However, the Brazelton
** Neonatal Behavioral Assessment Scale revealed that infants exposed to
** cocaine had significant depression of intera
** cocaine had significant depression of interactive behavior and a poor
** organizational response to environmental stimuli (state organization).
** These preliminary observations suggest that cocaine influences the
** outcome of pregnancy as well as the neurologic behavior of the
** newborn, but a full assessment will require a larger number of
** pregnancies and longer follow-up.
**
End of document reached

Continue? YES/NO/ALL/ORDER/HELP (YES))

Attachment 2

FLORIDA MEDICAL ASSOCIATION, INC.

Cocaine in Pregnancy

(MEDLINE Search of Medical Literature Conducted by
Borland Medical Library - October 7, 1987)

1. Smith JE; Deitch KV - Cocaine: a maternal, fetal, and neonatal risk - J Pediatr Health Care 1987 May-June; 1(3) : 120-4.

2. Bauchner H; Zuckerman B; Amaro H; Frank DA; Parker S - Teratogenicity of cocaine (letter) - J Pediatr 1987 Jul; 111(1) : 160-1.

3. Teske MP; Trese MT - Retinopathy of prematurity-like fundus and persistent hyperplastic primary vitreous associated with maternal cocaine use - Am J Ophthalmol 1987 May 15; 103(5) : 719-20.

4. Nichols CE; Clore ER - Neonatal nightmare: devastating effects of cocaine - Fla Nurse 1987 Feb; 35(2) : 5.

5. Bingol N; Fuchs M; Diaz V; Stone RK; Gromisch DS - Teratogenicity of cocaine in humans (published erratum appears in J Pediatr 1987 Mar; 110(3) : 350).

6. Hill RM; Tennyson LM - Maternal drug therapy: effect on fetal and neonatal growth and neurobehavior - Neurotoxicology 1986 Summer; 7(2) : 121-39.

7. Cregler LL; Mark H - Medical complications of cocaine abuse - N Engl J Med 1986 Dec 4; 315(23) : 1495-500.

8. Ward SL; Schuetz S; Krishna V; Bean X; Wingert W; Wachsman L; Keens TG - Abnormal sleeping ventilatory pattern in infants of substance-abusing mothers - Am J Dis Child 1986 Oct; 140(10) : 1015-20.

9. Chasnoff IJ; Bussey ME; Savich R; Stack CM - Perinatal cerebral infarction and maternal cocaine use - J Pediatr 1986 Mar; 108(3) : 456-9.

10. Madden JD; Payne TF; Miller S - Maternal cocaine abuse and effect on the newborn - Pediatrics 1986 Feb; 77(2) : 209-11.

11. Mullins CL ; Gazaway PM 3d - Alcohol and drug use in pregnancy: a case for management - Md Med J 1985 Oct; 34(10) : 991-6.

12. Lee CC; Chiang CN - Maternal-fetal transfer of abused substances: pharmacokinetic and pharmacodynamic data - Natl Inst Drug Abuse Res Monogr Ser 1985; 60: 110-47.

13. Chasnoff IJ; Burns WJ; Schnoll SH; Burns KA - Cocaine use in pregnancy - N Engl J Med 1985 Sep 12; 313(11) : 669-9.

14. LeBlanc PE; Parekh AJ; Naso B; Glass L - Effects of intrauterine exposure to alkaloidal cocaine ('crack') [letter] - Am J Dis Child 1987 Sep; 141(9) : 937-8.

15. Baxi LV; Petrie RH - Pharmacologic effects on labor: effects of drugs on dystocia; labor, and uterine activity - Clin Obstet Gynecol 1987 Mar; 30(1) : 19-32.

16. Braude MC; Szeto HH; Kuhn CM; Bero L; Ignar D; Field E; Lurie S; Chasnoff IJ; Mendelson JH; Zuckerman B; et al - Perinatal effects of drugs of abuse - Fed Proc 1987 May 14; 46(7) : 2446-53.

17. Woods Jr Jr; Plessinger MA; Clark KE - Effect of cocaine on uterine blood flow and fetal oxygenation - JAMA 1987 Feb 20; 257(7): 957-61.

18. Moore TR; Sorg J; Miller L; Key TC; Resnik R - Hemodynamic effects of intravenous cocaine on the pregnant ewe and fetus - Am J Obstet Gynecol 1986 Oct; 155(4) 883-8.

19. Zagon IS; McLaughlin PJ - Perinatal exposure to methadone alters sensitivity to drugs in adult rats - Neurobehav Toxicol Teratol 1984 Jul-Aug; 6(4): 319-23.

20. Kennedy JA; de la Lande IS - The effect of pregnancy on the metabolism of noradrenaline in reproductive organs of the rabbit - Naunyn Schmiedebergs Arch Pharmacol 1984; 326(2) : 143-7.

21. Calixto JB; Simas CM - Mechanism of action of isoprenaline, isoxuprine, terbutaline and orciprenaline on gravid human isolated myometrium. Influence of the neuroanal update process - Biol Reprod 1984 Jun; 30(5) : 1117-23.

22. Acker D; Sachs BP; Tracey KJ; Wise WE - Abruptio placentae associated with cocaine us - Am J Obstet Gynecol 1983 May 15; 146(2) : 220-1.

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24. Moisey DM; Tulenko T - Increased sensitivity to angiotensin in uterine arteries from pregnant rabbits - Am J Physiol 1983 Mar; 244(3) : H335-40.

25. Fantel AG; Macphail BJ - The teratogenicity of cocaine - Teratology 1982 Aug; 26(1) : 17-9.

26. Foldes A; James SB - In vitro noradrenaline accumulation by sheep skin; partial characterization and localization - Aust J Biol Sci 1981; 34(3) : 295-304.

27. Mahalik MP; Gautieri RF; Mann DE Jr - Teratogenic potential of cocaine hydrochloride in CF-1 mice - J Pharm Sci 1980 Jun; 69(6) : 703-6.

28. Shah NS; May DA; Yates JD - Disposition of levo-[3H]cocaine in pregnant and nonpregnant mice - Toxicol Appl Pharmacol 1980 Apr; 53(2) : 279-84.

Attachment 3

FLORIDA MEDICAL ASSOCIATION, INC.
Cocaine Handbook - Prepublication Text

COCAINE: The Drug

Cocaine is an addicting drug. It is an ester of benzoic acid and a nitrogen containing base (benzoylmethyleconine). Cocaine, in all of its forms, is ultimately obtained from the leaves of Erythroxylon Coca, a shrub-plant which grows naturally in the mountainside forest of South and Central America.

Cocaine is currently classified as a Schedule II narcotic, even though its primary biological activity is that of a stimulant. This classification has been accepted because cocaine still has an accepted medical use as well as an intense abuse potential. The medical profession has intended that the administration of cocaine be limited to dilute topical solutions used predominantly by ear, nose and throat specialists and by anesthesiologists in their traditional procedures and practices. In addition, cocaine has been used as an additive in Brompton's solution to provide pain relief for terminally ill cancer patients.

In virtually every county in Florida, cocaine is available on the street via illicit trafficking. The drug is known by several slang terms such as coke, snow, flake, Peruvian flake, gold dust, the lady, Bernice, the pimp's drug, the rich man's drug, crack, base or freebase. Cocaine is also available in crude paste form called "Basuco". This can be either chewed or smoked. Crack cocaine mixed with marijuana and smoked in a cigarette form is known as geak.

One of the main problems for the person who purchases cocaine from the street is that there is no quality control. Street cocaine may range in purity from 15 to 90%. It is cut with a variety of substances including mannitol, quinine, phenylpropanolamine, lidocaine or procaine. Soluble cocaine when mixed together with heroin and injected intravenously is known as speedball. The street price of cocaine generally has been going down over the past five years. A gram of

cocaine can cost as much as $3,000. A tiny "rock" of crack cocaine can cost as little as $5 to $10. The user of the drug can never be sure of the quality or the quantity of cocaine or of the percent of adulterants contained in the portion obtained.

COCAINISM: The Disease

It is estimated that 24 million Americans have tried cocaine and three million use it on a regular basis. It has become apparent over the past ten years that not everyone who uses the drug will become addicted. Rather, a group of these people will be selected out to become addicts by the highly addictive properties of the drug and by certain biogenetic and environmental factors.

Patients addicted to cocaine exhibit a progressive set of signs and symptoms characterized by craving and compulsion to use the drug, loss of control over the amount used, loss of control over behavior after usage and continued use in spite of adverse consequences. This modern day definition of addiction helps the clinician separate a group of patients who might have had scattered encounters with cocaine and were able to stop on their own from that group of patients who suffer damage to their personal, physical, or mental health, a destructive impact on their marriage and family life, disruption of normal healthy social relationships, deterioration in their area of employment, loss of financial resources and potential serious legal consequences and even death. The latter group we would diagnose as cocaine addicts. The natural history of untreated cocaine addiction leads to disruption in all areas of normal life as we know it, including premature death. With the help of professional intervention and treatment, a significant number of these patients can be treated and continue on with a happy and successful lifestyle.

The strong evidence for genetic, biochemical and environmental factors contributory to the addiction to alcohol are now being studied and established for cocaine addiction as well. Because the use of multiple addicting substances has become more prevalent in the 1980's, there is a tendency to see people entering hospitals for addiction treatment at an earlier age. Also, there is much evidence that patients addicted to alcohol will also become addicted to cocaine if they start to abuse the drug. The converse is also true. Data has shown that 70% of cocaine addicts in treatment have a family history of alcoholism. There are research investigations in multiple centers throughout the country designed to reveal more information about all chemical addictions. There is hope that populations, especially of young people, can be identified as high risk before the abuse of the drug begins.

The disease of cocainism does not develop overnight. However, its course can be extremely rapid, especially if cocaine is used in the intravenous, crack or freebase forms. The disease is relapsing and because it is potentially fatal, it must be intervened upon and treated aggressively by trained professionals.

MEDICAL SIGNS AND SYMPTOMS OF COCAINE ABUSE/DEPENDENCY:

Cocaine, like all mood altering drugs, exhibits its primary effect upon the brain and the central nervous system. The signs of cocaine use may be as non-specific as a slight giddiness, dilated pupils, muscle twitching and increased deep tendon reflexes. The most devastating neurologic manifestation is major motor seizure, which may be followed by cerebral hemorrhage, status epilepticus and death. Convulsions are not always dose related and in a person who is hypersensitive to the drug, small doses have been known to produce death after first time use. Cocaine leads to impaired judgment which may secondarily lead to serious injury to self or others by trauma. Cocaine psychosis usually follows repeated or binge use of the drug. The predominant feature of this

manifestation of toxicity is paranoia and unprovoked tendencies toward violence. Visual hallucinations are common during these episodes. Hyperpyrexia with temperatures in the range of 104 degrees and greater is thought to be mediated by the direct activity of cocaine on the temperature regulating center in the brain. Acute stroke syndromes have been reported secondary to intravenous cocaine use. This is thought to be mediated by the powerful vasoactive properties of the drug on sensitive cerebral vessels. In high doses, cocaine has been known to depress respiratory centers leading to eventual respiratory depression placing the patient at greater risk for cardiac arrhythmia and sudden death.

CARDIOVASCULAR

It is typical to find tachycardia, tachyarrhythmias and systolic and diastolic hypertension in patients who are high on cocaine. This may be followed by brady-arrhythmias because of a reflex increased vagal tone. Many overdose deaths from cocaine have been attributed to ventricular fibrillation. This may occur both in the presence and absence of coronary artery disease. Vascular spasm and small vessel vasoconstriction have been implicated as contributory pathological factors. Non-exertional anginal syndromes are seen in smokers of cocaine. Reports of chest pain can lead to non-diagnostic cardiac workups. However, further questioning might lead to an admission on the part of the patient of cocaine abuse.

When injected directly into a blood vessel, cocaine exerts a powerful vasoconstricting effect. Characteristic "target" lesions are seen on the skin of intravenous cocaine addicts. The lesions are produced by a central area of pallor with surrounding hyperemia secondary to local vascular changes. Repeated doses into an artery may produce distal necrosis, ulceration and gangrene. Since injectable cocaine is water soluble, it does not require heating for solubility. Therefore, it is uncommon to see pigmented "tracks" on the extremities of the intravenous cocaine addicts. It is more likely that the clinician would see ulcerative lesions.

EAR, NOSE AND THROAT

Since there are millions of people who inhale (snort) cocaine through the nostrils and because of the effect of cocaine on the nasal mucosa and vasculature, it is not uncommon for cocaine abusers to present to otolaryngologists and general physicians with complaints of acute and chronic rhinitis and sinusitis. Nasal septal ulcerations and perforations are seen in chronic cocaine addicts who use via the nasal route. Cases of bony erosion of the skull, cerebral spinal fluid leakage from the nose and an increased incidence in nasopharyngeal tumors have been reported secondary to chronic cocaine snorting.

Many of the materials used to cut cocaine which is used for snorting also have vasoconstrictive properties and this further contributes to nasal and sinus problems. Signs and symptoms of this nature might prompt the physician to question the patient concerning the use of cocaine. Pharyngitis, laryngitis and transient vocal chord paralysis can occur following the accidental aspiration of snorted cocaine or following chronic cocaine smoking.

RESPIRATORY

The inhalation of cocaine in the form of freebase or crack produces high blood levels of cocaine in a short period of time. As this is common knowledge among drug abusers, physicians will see more respiratory complications of this form of drug addiction. These usually present as non-specific complaints provoked by the patient's fear after experiencing chest symptoms while smoking cocaine. These may be as minor as fleeting sharp chest pains and cough or may be as serious as pneumothorax and hemoptysis. Because crude cocaine paste may contain organic solvents or acids, direct injury to the pulmonary system presents as

acute bronchitis without bacterial or viral symptomatology. An index of suspicion and careful questioning may lead to the appropriate clinical information.

GASTROINTESTINAL

Cocaine is known to depress the appetite center when used on a regular basis. The most rapid weight loss in the absence of other etiologies is seen in crack and freebase addicts. Patients thus present with a history of weight loss without other explanation. Family members may even be concerned about occult malignancy. Vitamin deficiencies and anemia may accompany this complication of cocaine addiction. Cocaine is well absorbed via the gastrointestinal tract. Oral administration is a highly unusual route of administration of the drug in cocaine addicts. Accidental death from overdose has been described in patients who were attempting to destroy "evidence" or otherwise conceal large doses of cocaine within the gastrointestinal system. A non-specific hepatitis characterized by a moderate transaminase elevation has been seen in cocaine addicts. Research is under way to determine the mechanism of the apparent hepatocellular damage. This phenomenon appears to be apart from the commonly identifiable viral forms of hepatitis seen in intravenous drug addicts.

REPRODUCTIVE-NEONATAL

One of the most potentially devasting effects of cocaine is being seen with more frequency in pregnant women. Multiple centers are studying the effects of cocainism and its effects on the various stages of pregnancy. In addition, newborn centers are examining the infants of cocaine addicted mothers to determine both short term and long term effects of the drug. Early results from human studies seem to corroborate the results of animal experiments. Cocaine can exert an effect on placental vessels leading to premature rupture of membranes and placental separation. This can lead to abrupt onset of labor, complicated deliveries and potential fetal damage. There is evidence to indicate that low birth weight, possible mental impairment and withdrawal states can occur in the infants of cocaine addicted mothers. Clinical studies are being carried out in order to provide more information on this extremely important area of medicine.

BEHAVIORAL SIGNS OF COCAINE ABUSE/DEPENDENCY

The age range of the cocaine abuser or addict is extremely wide. Patients have been seen with cocaine dependency in the pre-teen years. Also, patients with complications of cocaine abuse have been seen well into their 70's. The average American cocaine abuser will be approximately 30-35 years old. The average length of use or abuse of the drug before adverse consequences present themselves can be as short as six weeks for crack cocaine smoking or as long as five to ten years for chronic low dose cocaine snorting. Approximately 30% of cocaine abusers are women. The vast majority of cocaine abusers are white and earn an annual income of $25,000 or more. Cocaine knows no occupational bounds. The well-educated groups including physicians, attorneys, airline pilots, teachers, high level business people and the clergy are represented in treatment populations. Over the course of time, a typical behavioral pattern characteristic of the cocaine abuser may become apparent to a treating physician. Many times the information will be gathered from a spouse, loved one, parent or child of the addict who came to the physician looking for relief from stress related illnesses secondary to living with or attempting to deal with the addicted person. A pattern of wide mood swings, unpredictable behavior, irresponsibility and/or violence within the home may be the first signs indicative of a cocaine drug problem. Periods of rapid weight loss alternating with binge eating patterns, long unexplained absences from the home or work place, diminishing economic reserve or even the pawning of household items or jewelry are more advanced signs. Chronic lying, the tendency to blame others for addiction related problems and withdrawal from normal family or social activities are characteristic. Absenteeism from the work place, diversion of business funds for the purchase of cocaine, frequent trips to the

lavatory while on the job and diminishing work performance are all typical signs. Deteriorating personal demeanor, dress and hygiene are commonly seen secondary to advanced cocaine dependency. Chronic sniffing, chronic anxiety states and fullblown paranoid states are seen in the late stage addiction period. Wide fluctuations in sexual mood accompany the course of cocaine dependency. In early stages, a hyper-sexuality phase may be present. As the addiction progresses, loss of libido and frigidity are common as the patient becomes totally obsessed with the drug itself. Abnormal behavior within formerly stable family members is common in cocaine addiction. Reports by family members of illegal activities, a change in the type of social association may alert the physician to cocaine-related problems. Rarely do addicted patients present themselves to their physician fully admitting the problem and asking for help. Rather, longitudinal follow-ups of an accumulation of episodic drug related consequences lead to the diagnosis.

COCAINE TOXICITY

Serious medical consequences secondary to the use of cocaine do not always require long-term abuse or high doses of the drug. Idiosyncratic-like reactions following small amounts of cocaine have been reported to result in sudden death. Sudden death has been reported in infrequent or first time cocaine users who were unaware of cerebral vascular malformations. Also, sudden death secondary to trauma and suicide is well known in episodic cocaine abusers. For these reasons, advice from physicians to patients asking questions concerning the "safe use" of the drug cocaine must be that cocaine is a highly addictive drug which may produce sudden death with little or no warning when taken in any amount or by any route.

TREATMENT OF COCAINE ABUSE/DEPENDENCY

Physicians working in community as well as in inner-city based emergency rooms are seeing more and more patients presenting with acute cocaine overdose and toxicity. Patient may present with agitated, confusional or anxiety states which require only reassurance and a period of obervation to assure stability. More serious cases present with a combative state, marked hypertension, cardiac arrhythmias, seizures and impending cardio-respiratory collapse. These cases may require intravenous sedation and full cardio-respiratory support. Once stability is achieved, usually only a few hours are required for life threatening signs to disappear as the liver detoxifies the system. Once diagnostic signs of cocaine abuse or dependency are recognized, it is recommended that the medical team refer the patient to substance abuse treatment. Likewise, when office based physicians make the diagnosis of chronic cocaine abuse or suspect that this may be the case, referral for treatment or further consultation is indicated. There are many reputable addiction treatment programs in the State of Florida. These facilities can provide help for patients and their families who can afford to pay for private medical care, or who are funded by third party sources. Sadly, many patients in need of treatment for cocaine abuse come to the attention of the physician after resources have been depleted as a consequence of the addiction. For this type of case, there must be close networking with community social service agencies in order to provide the care needed. Patients who are recognized as having the problem of substance abuse or dependency, in addition to formal referral and treatment, are recommended to attend self-help support groups such as Narcotics Anonymous and Cocaine Anonymous. Family members are advised to seek the help of Alanon, Naranon or Families Anonymous. These self-help support groups are vital to the recovery of the addicted patient and their loved ones. Their contact numbers can be found in most local phone directories. These groups teach total abstinence from all mood-altering substances and provide a mechanism for the patient and family members to take responsibility for their own recovery.

Attachment 4

APR 20

UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE

William B. Deal, M.D.
Dean and Associate Vice President
for Clinical Affairs

J. Lee Dockery, M.D.
Executive Associate Dean

Box J-215, JHMHC
Gainesville, Florida 32610
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April 13, 1987

Joseph H. Deastch, M.D.
Chairman, Committee on
Substance Abuse
Florida Medical Association, Inc.
1025 Rosselle Street
Jacksonville, Florida 32204

Dear Dr. Deastch:

Thank you for your letter of April 6, concerning chemical addiction and curriculum content in the College of Medicine on substance abuse. The following are courses offered in the College of Medicine curriculum covering substance abuse:

Pharmacology (BMS 5460): In this second-year course, a total of five lecture hours is devoted to basic science aspects of substances of abuse. It is in this course that our students are taught the pharmacologic mechanisms of action of these drugs in the central nervous system, including specific discussions of tolerance, psychological versus physical dependence, and withdrawal. Our lecturers spend about one hour on general principles and then, in specific applications, spend two hours on the opiates, one hour on alcohol, and one hour on cocaine and marijuana.

Social and Ethical Issues in Medical Practice (BMS 5822): This course allots a two-hour session on substance abuse stressing ethical and sociological aspects of this problem. The faculty who lead group discussions spend time in this course on the impaired physician, discussing with students services available to physicians and problems that arise as colleagues of impaired physicians.

Disorders of Thinking, Emotion and Behavior (BCC 5151): This second-year, pre-clinical course offered by the Psychiatry Department introduces students to recognition of the symptoms of drug abuse and modes of treatment. Three hours are allotted to this topic.

EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Psychiatric Clerkship (BCC 5150): It is in this clerkship that students have firsthand interaction in dealing with the psychiatric aspects of treatment of drug abuse.

Advanced Pharmacology (BMS 5465): This third-year course which follows student clerkships devotes one lecture hour to the clinical pharmacology of substance abuse.

The Drug Culture (CMC 4): This is a fourth-year elective course which is chosen by up to twelve students per class. It extends for four weeks and a total of sixteen student-faculty contact hours. The course comprises seminar sessions, field trips, and clinical presentations to further familiarize the student with the effects of and treatment for the abuse of drug substances.

Each of these courses covers the range of substances of abuse: cocaine, opiates, barbiturates, hallucinogenic agents, and alcohol. Moreover, in these courses and in many courses concerned with drug toxicity, the students are taught the effects and treatment of excessive doses of over-the-counter and prescription medications. Because many of these topics are interrelated, it is difficult to pick out one substance in particular, such as cocaine, and quantitate the hours it is taught to students.

In addition, the University of Florida College of Medicine works very closely with the Impaired Physicians Program. Dr. Roger Goetz has presented seminars at the University of Florida College of Medicine and has been very assistive in instances of intervention with impaired students and housestaff. The Committee on Substance Abuse of the Florida Medical Association is to be commended for its interest in influencing medical education in the important topics of chemical addiction and substance abuse.

Sincerely,

William B. Deal, M.D.

WBD:mft
cc: Joseph T. Ostroski, M.D.
Pierre J. Bouis, Jr., M.D.
James B. Perry, M.D.
Mr. Donald C. Jones
J. Lee Dockery, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

For Release Only Upon Delivery

STATEMENT

BY

CHARLES R. SCHUSTER, Ph.D.

DIRECTOR

NATIONAL INSTITUTE ON DRUG ABUSE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

OF THE

HOUSE OF REPRESENTATIVES

ON

COCAINE BABIES

BROWARD GENERAL MEDICAL CENTER, FORT LAUDERDALE, FLORIDA

9:00 A.M.

OCTOBER 16, 1987

Mr. Chairman and members of the Committee, I am Dr. Charles R. Schuster, Director of the National Institute on Drug Abuse (NIDA) of the Alcohol, Drug Abuse, and Mental Health Administration. We are grateful for the opportunity to participate in this hearing on the tragic phenomenon known as "cocaine babies."

Nature and Extent of the Problem:

Recent years have seen a gradual decline in the use of most illicit drugs by young Americans--with one very serious exception. NIDA's 1986 survey of high school seniors showed that use of cocaine continued at peak levels. Unfortunately, 17.6 percent of the males and 14.7 percent of the females surveyed had used cocaine during the past year, either in powder form or in the form known as "crack," a smokable form of the drug. Cocaine is now used by more high school seniors than any other illicit drug except marijuana.

An especially disturbing fact is that only a third of the students surveyed believed that experimenting with cocaine was dangerous to the user. A survey of attitudes and knowledge about illegal drug use was conducted shortly after the deaths of Len Bias and Don Rogers and showed an increased awareness of cocaine's danger. However, despite all the publicity about cocaine's addictive potential and toxic effects, it continues to be used by large numbers of people. Confirmation of this comes from NIDA's Drug Abuse Warning Network (DAWN) data collection effort, a survey of 750 hospital emergency rooms in 27 major metropolitan areas. In 1986, energency room mentions of cocaine surpassed mentions of "alcohol in combination with other drugs" for the first time ever.

Let's take a look at the routes of administration that people use in taking cocaine. NIDA's eighth National Household Survey was conducted in 1985, and data were collected on drug use in a representative sample of the U.S. household population age 12 and over. This survey found that 95% of cocaine users have taken the drug intranasally ("snorting"). Eight percent have injected cocaine intravenously (thus adding the risk of contracting AIDS through use of shared needles). In addition, 44% of youth age 12-17, 21 percent of young adults age 18-25, and 19 percent of adults age 26-34 have smoked freebase cocaine. Crack is a form of freebase, and it is easy to manufacture, highly addictive, and inexpensive to purchase. All the smokable forms of cocaine are particularly dangerous since this route readily allows the user to ingest large quantities which are toxic to the heart and brain and, of course, the fetus if the user is pregnant. Smoked cocaine accounted for a quarter of all the cocaine-related DAWN mentions in 1986. Thus, people of childbearing age and those about to enter their childbearing years are using cocaine, and using it in all its dangerous forms.

To date, most research has dealt with the broader picture, as outlined above. Less is known about the specific problems we are discussing today. This is the case partially because there are problems inherent in attempting to determine effects of cocaine on pregnant women and their offspring. Women who use cocaine are often polydrug abusers, so that the effects of cocaine alone may not be separable from the effects of a combination of illicit substances.

The effects of poor nutrition and limited prenatal care for the mothers must also be considered as confounding variables in research studies. In addition, researchers must look at the point during the pregnancy when cocaine is used, the purity of the substance taken, whether it is used occasionally or repeatedly, and how much is used at particular times.

The scale of the problem as it affects newborns is known only to a limited degree. Reports from small studies indicate that 10 to 20 percent of the infants delivered of mothers involved in drug treatment programs in various parts of the country tested positive for cocaine. However, these figures can't be applied to the general population. Remember, also, that the figures are probably low because they represent the results of drug screens done on infants at birth, and would not show a women's use of drugs earlier in the pregnancy.

There is still less data about the extent of fetal loss that might be attributable to cocaine usage by pregnant women. The pharmacological effects of cocaine on the sympathetic nervous system make it likely that the substance would increase fetal activity and produce spontaneous abortions. Cocaine acts to increase the level of the substance known as norepinephrine, and these raised levels have been shown to increase the tendency of the uterus to contract. A small study in Chicago showed that cocaine-using women in a perinatal addiction program were more likely to have first trimester spontaneous abortions and third trimester premature labor and placental abruption than opiate-addicted women who had not used cocaine. A Philadelphia study indicated similarly that fetal and infant loss are higher in cocaine-using women than in women who were being treated with methadone.

Cocaine-related interruption of the blood supply to the fetus may result in a spectrum of abnormalities. The outcome of the constriction of blood vessels may be a crippling stroke. Cases of cerebral infarction (stroke) in infants immediately after birth have been connected with use of large quantities of cocaine by women in the final days of pregnancy. A less dramatic but equally handicapping outcome may be found in the child with developmental abnormalities, including stunted growth, cardiovascular impairment, and long-term behavioral problems. It is important to take note of this, in that these long-term effects differentiate cocaine from many other drugs, such as opiates, for which withdrawal is the primary problem. Cocaine babies may suffer far fewer withdrawal symptoms and shorter withdrawal periods than babies born addicted to heroin. Cocaine babies, however, as is also the case in babies whose mothers abuse alcohol and some other drugs, may have problems that will require medical care and social support over a period of years, or even a lifetime. When the cocaine was taken intravenously and sharing of needles occurred, there is also an increased risk of the mother and child contracting AIDS. The cost to society is impossible to estimate.

Not all of these children will survive, not even with adequate treatment and assistance. Infants exposed to cocaine in utero are vulnerable to apnea and other abnormal respiratory patterns. An increased incidence of sudden infant death syndrome (SIDS) has been reported in these infants.

NIDA's Response:

The Institute is addressing the complex issues just outlined through a number of initiatives.

- NIDA has launched research initiatives on the role of drug abuse in adolescent pregnancy, particularly among Black youth, and on the effects of maternal drug use during pregnancy. Attention is being given to prevention, prenatal care, diagnostic measures, and developmental interventions.

- Several related research studies are currently under consideration at NIDA. One would explore the extent of the risk of fetal loss and infant death in children of cocaine-using women. Another would look at the epidemiology of maternal substance abuse in pregnancy.

- Under contract to NIDA and NIAAA, the American College of Obstetricians and Gynecologists will develop curricula aimed at teaching clinicians to recognize and manage drug abuse in their patients. These will be used in medical schools and for staff training in hospitals and other health care settings.

- With technical assistance and consultation provided by NIDA, the Healthy Mothers, Healthy Babies Coalition has produced educational materials such as "Drugs and Pregnancy," for health professionals and the public. These materials have been distributed widely to public interest and consumer groups as well as to national and professional organizations.

- The Institute has conducted state-of-the-art reviews on the relationship of teenage pregnancy and substance abuse, which is believed to contribute to the initiation of sexual activity. Some thirty thousand girls under 15 become pregnant each year. In fact, forty-six percent of all births to unmarried women are to teenage mothers. As a result of the technical reviews, grant activity has been stimulated in this area as well as on the effects of drugs of abuse on the pregnant woman, the fetus, and the neonate.

- NIDA is working with the Health Resources and Services Administration to ensure that drug abuse concerns are considered in their maternal and child health projects.

- In the FY 1988 Budget, the Department of Health and Human Services has proposed an $85 million program of demonstration grants calling for the development and implementation of case-managed, comprehensive prenatal and infant services for Medicaid-eligible women and their infants. This program is to be administered by the Health Care Financing Administration with input and advice from other Departmental organizations, including NIDA.

- NIDA's Drug Abuse Information and Referral Line (1-800-662-HELP) provides callers with referrals to State and Local treatment programs. Callers are given extensive information about the health consequences of using drugs, both for themselves and for their offspring.

In summary, NIDA shares your concern about the effects of illicit substances, and particularly of cocaine, on pregnant women and their offspring. There is much work to be done, and we look forward to working with you toward defining, preventing, and diminishing the serious problems being discussed today.

STATEMENT

of the

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

on

SUBSTANCE ABUSE AND PREGNANCY

Presented by

Robert J. Sokol, MD, FACOG

before the

Select Committee on Narcotics Abuse and Control

U.S. House of Representatives

October 16, 1987

Mr. Chairman, Members of the Committee, I am Robert James Sokol, MD, Chairman of the Department of Obstetrics and Gynecology at Wayne State University and on the staff of Hutzel Hospital in Detroit. Throughout my career in research, I have published extensively in the area of substance abuse with emphasis on the abuse of alcohol. Recently I served as Steering Committee Chairman to oversee a contract awarded to the American College of Obstetricians and Gynecologists (ACOG), which examined the role of medical education in drug and alcohol abuse in obstetrics and gynecology. I appreciate this opportunity to appear before you today on behalf of ACOG, an organization representing more than 26,000 obstetricians and gynecologists, to discuss the important issue of drug abuse and pregnancy and the efforts we are undertaking to educate our members about this serious problem.

DRUG ABUSE AND PREGNANCY

Drug abuse is commonplace in our society. With the increased use of drugs among younger segments of the population, drug abuse in pregnancy now occurs with relative frequency. Some of the most commonly abused illicit drugs include marijuana, cocaine, barbituates, and opioids. In addition to these illicit substances, prescription drugs, alcohol, caffeine, and tobacco are also often abused.

The use of illicit drugs is frequently associated with problematic lifestyles. The purchase of such drugs on a regular basis may be financed by criminal activities, including theft and prostitution. Individuals who use drugs that produce debilitating sensory effects may be unable to hold a job or to provide for themselves adequate nutrition, clothing, and shelter. Recently there has been an increase in drug abuse among affluent people whose recreational use of drugs such as cocaine and marijuana may be within their financial means. For such people, there may be no deficiency in nutritional or general health status. However, continued abuse of certain agents, such as alcohol, is associated with a progressive deterioration in nutrition, employability, and general health, even among the more affluent.

A notable trend in drug abuse is the use of more than one drug at a time. The development of multiple-drug habits often alters or intensifies the desired effects of each drug. In some instances a drug may be used to counter the adverse effects of another drug. For example, the combined use of cocaine with an opioid, prevents the excitability associated with the use of cocaine alone. Frequently, women abuse other drugs in combination with alcohol. This pattern of multiple-drug use often makes it difficult for the health care provider to assess the effects of drug use on pregnancy.

Certain abused drugs have well-documented direct, negative effects on the fetus. For example, women suffering from chronic alcoholism may give birth to infants with the fetal alcohol syndrome (FAS). This syndrome consists primarily of underdeveloped midfacial structures, microcephaly, mild to moderate mental retardation, and retardation in body growth. In many instances, however, the drug-abusing woman is prone to complications in pregnancy because of factors associated with her lifestyle. Nutritional deficiencies are seen with the use of certain drugs, particularly opioids, which are associated with anemia, fetal growth retardation, and possibly, an increased incidence of preeclampsia (toxemia in late pregnancy). The lifestyles of some drug-abusing women, especially prostitutes, results in a high incidence of sexually transmitted and other infectious diseases. Intravenous administration of drugs is associated with endocarditis (inflammation of the lining of the heart), hepatitis, and acquired immunodeficiency syndrome (AIDS), any of which can pose serious problems during pregnancy. If a women becomes or is already pregnant and tests positive for HIV, she may transmit the virus to her fetus. The Centers for Disease Control estimates that her infant has up to a 65 percent chance of acquiring the disease before birth. Most of these infants will die at around the age of two years.

In recent years, cocaine abuse has become of particular concern to obstetrician-gynecologists. Is is estimated that approximately 20 million people in the United States have used cocaine at least once and that 5 million individuals now use it

regularly. Cocaine can be administered intravenously, intranasally, or can be smoked. Often the drug is consumed over a period of several days during which little is eaten or drunk. Intoxication with cocaine may be associated with convulsions, cardiac arrhythmias, hypertension, and hyperthermia. Because of the overall increase in its use in the general population, it can be expected that increasing numbers of women are using cocaine during pregnancy. Although the drug is not associated with a known fetal anomaly syndrome such as FAS, the disruptive effects of habitual cocaine use on maternal nutrition and temperature control and its association with severe hypertension, miscarriage, premature detachment of the placenta, stillbirth, and congenital anomalies, are special causes for concern during pregnancy. Recent reports in the literature indicate that cocaine use during pregnancy may be associated with neurological deficits of the retina and iris in infants. The specific impact of cocaine use on the fetus is probably related not only to the quantity used but also to the timing of fetal exposure during pregnancy.

Infants born to women addicted to cocaine are often born addicted to the drug. These babies tend to be irritable at birth and must undergo cocaine withdrawal. Therefore, delivery should take place in a facility which is equipped to handle high-risk obstetrics and the management of possible neonatal complications. Studies to determine the long-term neurological effects of maternal cocaine use on infants are essential.

Obstetrician-gynecologists can play a crucial role in identifying and educating drug-abusing women, especially those who are planning pregnancy or are already pregnant. Many women are not aware of the harmful effects that drugs may have on the fetus. An initial prenatal care visit should include questions about the use of any drug including alcohol, tobacco, prescribed medicines, and illicit substances. Obstetrician-gynecologists should review a patient's previous obstetric and medical history. Other signs of drug abuse include physical exhaustion, extremely dilated or constricted pupils, disheveled physical

appearance, lack of patient orientation, and inflamed nasal membranes in the case of cocaine abuse. By all means, the physician must approach the patient in a tactful, nonthreatening, nonjudgmental manner. Physicians should provide patients with nutritional information and emphasize the importance of prenatal care visits. Also, referral to a social worker, clinical specialist, inpatient or community facility for chemical dependency treatment may be necessary. Therefore, health care providers, including obstetrician-gynecologists, should be familiar with available treatment sources.

In addition to the obstetric and medical problems of drug abuse in pregnancy, it is important for obstetrician/gynecologists to recognize that drug-abusing women may have an uncooperative attitude toward medical care. Many women may, in fact, deny their chemical dependency and may delay seeking prenatal care. Although it would be ideal for drug-abusing women to give up their habits prior to conception, it must be assumed that many users of addictive drugs will not be able to control their abuse of these substances during pregnancy. In these instances, it is still incumbent upon the health care provider to reinforce those factors known to improve perinatal outcome, most notably prenatal care visits and good nutrition including supplements, and to refer the patient for further treatment for her drug dependency.

ACOG EFFORTS TO EDUCATE PHYSICIANS

The American College of Obstetricians and Gynecologists publishes several documents to educate physicians and patients about women's health care. In the area of drug abuse, ACOG published a technical bulletin in September 1986 entitled "Drug Abuse and Pregnancy." Designed for physicians, this document reviews the effects of several illicit and legal substances and their effects on pregnant women. It also summarizes the effects of cocaine abuse on women and their infants. The College has published patient education pamphlets on "Smoking and Women", with a section on the harmful effects of smoking

during pregnancy, and "Alcohol and Your Unborn Baby" which describes the fetal alcohol syndrome (FAS).

Distributed to our 26,000 members, ACOG's Standards for Obstetric-Gynecologic Services, Sixth Edition, 1985 advise the physican that "The patient's nutritional status and habits should be evaluated during the initial visit and monitored throughout pregnancy, particularly in relation to smoking, alcohol use, or the ingestion of other drugs." The Standards also advise that the health history obtained by the physician include a review of the "ingestion of certain drugs and alcohol." In addition, the Guidelines for Perinatal Care, published jointly by ACOG and the American Academy of Pediatrics, counsel the physician to assess patients for alcohol or other drug addictions. Several references to drug abuse and women are included in PROLOG - the Personal Review of Learning in Obstetrics and Gynecology, a self-assessment program developed by ACOG. Subjects covered include such wide-ranging topics as "Characteristics of Fetal Alcohol Syndrome" and "Consequences of Maternal Heroin Addiction." The ACOG also sponsors "ACOG Update," a monthly series of audio cassette programs available through an annual subscription. These tapes include "Drug Addiction in Pregnancy", including information on the obstetric complications associated with cocaine abuse, and "Smoking and Reproduction."

In addition to these written and audio cassette materials, ACOG sponsors several postgraduate courses designed to acquaint the practicing obstetrician/gynecologist with the most recent clinical data in the field of obstetrics and gynecology. Two courses are scheduled for 1988 which will highlight the problems of substance abuse and pregnancy — "Common Problems in Obstetrics" and "High Risk Obstetrics". In addition to these specific programs, approximately 25 ACOG postgraduate courses sponsored in 1986 referred to substance abuse. It is expected that a similar number of courses will refer to this topic throughout 1987.

In 1986, ACOG was awarded a contract by both the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to conduct a project entitled "The Identification and Assessment of Alcohol and Drug Medical Education Project/Approaches in Obstetrics and Gynecology." As Chairman of the Steering Committee which conducted the study, I had the opportunity to review extensively the current status of drug abuse training in the field of obstetrics and gynecology. The purpose of the contract was to identify and assess the products, stategies, and approaches currently being utilized to integrate drug and alcohol use and abuse information into obstetric-gynecologic training programs. The contract also authorized the development of guidelines for implementation of a comprehensive educational strategy which incorporates drug and alcohol education throughout all levels of medical training including undergraduate, graduate, and continuing medical education. Minimal alcohol and drug related knowledge and skill statements for each level of the obstetric-gynecologic educational experience were developed. The final project report was completed at the end of September 1987.

Information on the current status of medical education in drug and alcohol abuse was obtained through medical school site visits and research of various medical education programs, publications, and other resource materials. Results of the study indicated that very little specialty specific information regarding drug and alcohol abuse is imparted in any level of medical education with the exception of continuing medical education programs aimed at practicing physicians. It is clear from the interest of our members in these courses that there is an on-going need to provide continuing medical education in the area of substance abuse.

As a result of the contract, recommendations for addressing the educational gaps for drug and alcohol abuse in medical education were defined. At the undergraduate level, ACOG recommends that primary education should occur in obstetrics/gynecology,

pharmacology, pediatrics, internal medicine, psychiatry, and family practice. The ACOG also recommends direct clinical experience for medical students such as exposure to substance abusers in drug treatment facilities and ambulatory care settings. Special emphasis by medical school departments of obstetrics and gynecology for training in substance abuse during pregnancy is also highlighted. At the residency level, ACOG recommends clinical experience in substance abuse detection and management as a key educational strategy.

In addition to the materials already developed by ACOG for the practicing physician, it is recommended that the College examine and expand its educational objectives in substance abuse as reflected in such documents as PROLOG. It is also recommended that simple screening questionnaires for substance abuse should be publicized to ACOG physicians. At the continuing medical education level, it is suggested that objectives and self-assessment questions focus on drugs and alcohol as they complicate pregnancy and that additional attention be given to all areas of substance abuse at ACOG national meetings, postgraduate courses, and audio cassette materials.

Included in the final report is an implementation plan designed to impart drug and alcohol abuse education and to foster the development of the knowledge and skills desirable for such education. Our organization has already begun to implement some of the Steering Committee's recommendations. For example, the entire report has been referred to ACOG's Learning Resources Commission, the educational arm of the College, as well as the Health Care Commission, the medical practice arm. Other relevant recommendations have been and will continue to be referred to appropriate ACOG committees. The Steering Committee has already requested that the Risk Assessment Statement included in the Guidelines for Perinatal Care be updated to identify more fully substance abuse among patients. In addition, ACOG will refer several recommendations to appropriate educational bodies, including such groups as the Association of Professors of Gynecology and Obstetrics (APGO),

the Residency Review Committee for Obstetrics and Gynecology (RRC), and The American Board of Obstetrics and Gynecology, Inc. (ABOG).

In conclusion, ACOG acknowledges the serious effects of drug abuse on pregnancy. Several complex social issues underlie drug abuse in our society which often hinder identification and treatment. We recognize the crucial role that obstetrician-gynecologists can play in identifying and educating patients on the negative effects of substance abuse. Although ACOG has undertaken the development of several educational materials to educate both physicians and patients on the issue of substance abuse, it is clear that more needs to be done to address this problem. To that end, our organization recommends the following:

1) Increase funding for basic medical research on the effects of drug abuse on women and the pregnancy-related consequences of substance abuse. Little information exists in the literature on cocaine abuse and pregnancy or the long-term effects of such abuse on infants.

2) Increase funding for research on the psycho-social problems associated with substance abuse.

3) Increase efforts, both by the federal government and the private sector, to educate the public on the harmful effects of drug abuse, especially during pregnancy.

4) Increase the availability of drug treatment centers and health care workers trained to counsel, educate, and treat individuals who abuse drugs.

5) Increase emphasis by national organizations such as ACOG to educate physicians and nurses on the detection, treatment, and prevention of substance abuse. Continue development of patient education materials by such organizations.

I will be pleased to answer any questions.

March of Dimes
Birth Defects Foundation
National Public Affairs Office
1725 K Street NW Suite 814
Washington DC 20006
Telephone 202 659 1800

MARCH OF DIMES STATEMENT

ON

PREVENTING BIRTH DEFECTS CAUSED BY MATERNAL DRUG USE

BEFORE THE

HOUSE SELECT COMMITTEE ON NARCOTICS

OCTOBER 16, 1987

Mr. Chairman and Members of the Committee, the March of Dimes Birth Defects Foundation is pleased to testify at this hearing on cocaine's children. This is an area of great concern to the March of Dimes. The public has been widely warned about the dangers of cocaine to users. But not enough has been reported about the drug's effect on unborn babies.

Virtually everything consumed by a pregnant woman reaches her unborn child -- including unprescribed and illicit drugs. These substances can pass directly through a woman's bloodstream to her fetus, and may cause physical or mental defects that last a lifetime.

The tragedy of these birth defects is that they are preventable. The March of Dimes recommends that pregnant women do their part-- that they avoid the use of illicit or recreational drugs entirely and that they contact a physician before taking any over-the-counter or prescription medication.

Meanwhile the March of Dimes is doing its part -- combatting the problem on a number of fronts:

IN THE LABORATORY

March of Dimes medical researchers are examining such issues as:

- o How the chronic use of drugs like marijuana and PCP by pregnant women affects newborn health and development.

- How and why Accutane, a vitamin A compound used to treat acne, causes severe birth defects if taken during pregnancy.
- How the anticancer drug cyclophosphamide, when given to males, can cause birth defects or miscarriage.
- How the synthetic hormone diethylstilbestrol (DES) -- often linked to birth defects of the reproductive system -- affects children of women who used it while pregnant.

IN THE COMMUNITY

- National student organizations including Future Homemakers of America (FHA), Future Business Leaders of America (FBLA), and the American Medical Student Association (AMSA) are conducting March of Dimes peer education programs about the risks of drug use during pregnancy.
- Employers are promoting good health messages through Babies and You, the March of Dimes preventive health education program for the workplace.
- March of Dimes chapters throughout the country are sponsoring seminars, panel discussions and community education projects on the subject of drugs and pregnancy.

THROUGH THE MEDIA

- Radio and television Public Service Announcements bring

March of Dimes messages into millions of homes.

- The suffering of cocaine-addicted infants is shown in a March of Dimes Video News Release that was sent to television stations across the country to use as part of their news programming.
- At a media symposium on drug use during pregnancy, the March of Dimes brought together leading experts and the press to get the latest information on the risks to the public.

THROUGH THE LEGISLATURE

- The March of Dimes continues to alert public officials at the national, state and local levels about the risks of substance abuse during pregnancy.
- March of Dimes medical experts testify in related national and state hearings.

Ultimately it is the pregnant woman who must weigh the use of unprescribed drugs against the very real possibility of harming the fetus -- and herself. The March of Dimes believes women must have access to the best available information to protect themselves and their children from birth defects.

We congratulate you on holding this important hearing.

SUBMISSIONS FOR THE RECORD

Sun Life OB/GYN SERVICES, INC.

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Select Committee on Narcotics Abuse and Control

Cocaine Abuse in Pregnancy

Sunlife Obstetric/Gynecologic Services provides obstetric care to much of the population affected by cocaine addiction. It is a private cooporation, formed in 1983, which contracts with hospitals to care for unassigned OB/GYN patients. We service several Florida hospitals as well as others in more northern and western states. Our physicians are fully trained, certified or eligible for certification by the American College of Obstetrics and Gynecology. We deliver between 70-80% of the nearly 6,000 patients treated at Broward General Medical Center and account for 40% of all deliveries in Broward County. Although we primarily provide obstetric care to an economically disadvantaged population, all races are represented in our treatment clientele. Broward General is a level 3 maternity hospital (capable of managing complicated pregnancies and has a neonatal intensive care unit), hence our practice approach is geared to facilitate care of the high risk patient. (High risk, meaning that the outcome of pregnancy has a less than optimal prognosis.)

As a drug, cocaine belongs to the class of compounds known as sympathomimetics or stimulates which among other things cause blood vessels to constrict. During the first 12-20 weeks of pregnancy, cocaine appears to be a teratogen and is associated with multiple congenital anomalies involving the heart (mitral valve defects, small left ventricle, aortic valve defects and coartation of the aorta), the extremities (polydactaly), the kidneys (hydronephrosis) and chromosomal aberrations suspected of producing decreased total chromosome compliment (Turner's Syndrome 45 X). Fetal loss during the first 20 weeks of pregnancy is expressed as spontaneous abortion. The later stages of pregnancy produce fetal death in utero or severely growth retarded infants with a significant risk of sucumbing to S.I.D.S. (Sudden Infant Death Syndrome). The lack of growth, presumably, is due to poor nutrician, severe anemia and chronic oxygen deprivation caused by decreased uterine blood flow. One rather elegant experiment involving the medical researcher's best friend, the pregnant sheep, demonstrated a 40% reduction in utero-placental blood flow lasting 7-8 minutes following intravenous administration of cocaine. The consequences of such a catastrophy could

easily be lethal to an already compromised fetus. Such clinical experiments are, of course, not feasible in humans. However, women using cocaine do relate intense uterine contractions and rapid fetal movements after cocaine use. The goal of obstetrics is to deliver a healthy infant while perserving and promoting the health of the mother. In the case of maternal cocaine addiction, the primary treatment modality, prenatal care, is most frequently denied. Pregnant patients using cocaine constitute a no win situation. Since even if prenatal care is obtained, lack of compliance produces less than desired results. In short, cocaine abusing mothers represent one of the most unsolvable management problems in obstetrics.

Such patients frequently present with hypertension and heavy vaginal bleeding due to premature separation of the placental (placental abruption). The infant, still in utero, often exhibits heart rate patterns diagnostic of fetal distress and impending death.

The patient who has recently used cocaine is typically brought to the delivery suite by emergency medical technicians since no plan of transport has been considered. She has no prenatal care, hence no medical records. The patient is physically violent, verbally abusive, responding to medical inquires with statements of paranoid accusations. Quite frequently, the patient must be restrained to protect both herself and the staff from injury. Sedation and other pain medications cannot be safely used since their interaction with unknown street drugs are too unpredictable. Labor is generally short owing to intense uterine contractions. Delivery by cesarean section is not infrequent since such patients often show fetal distress. Conversely, vaginal delivery presents significant peril to the patient, the physician, and the delivering infant due to its often uncontrolled, precipitous nature.

Perhaps the best way to dramatize the sense of futility felt when treating cocaine addicted mothers is to briefly describe two such patients that delivered here within the past thirty days.

Patient A is a 23 year old without the benefit of prenatal care. This is her second pregnancy, the first ending in spontaneous abortion. She arrived by ambulance, struggling with attendants, and screaming obsenities. The patient was anemic (hct 27%). Cultures and blood acessment revealed syphilis, gonorrhea, and past hepatitis. A.I.D.S. screen was negative. Within thirty minutes of arrival she delivered a growth retarded (weighing 3 lbs. 1 oz., 36 weeks gestation). Female infant requiring additional oxygen to adequately breath. The infant no longer requires oxygen support but remains in neonatal intensive care and required treatment for congenital syphilis.

Patient B is a 26 year old separated, unemployed, medicaid recipient who has had six children. She received prenatal care at Broward's High Risk Clinic and is 36-37 weeks gestation. She attended a drug rehabilitation program during this pregnancy. Hospital arrival was by private owned vehicle. The patient last delivered in August, 1986. That infant weighed 6 lbs. 14 oz. with urine which tested positive for cocaine. The pregnancy prior to this occured 1985. That infant weighed 5 lbs 14 oz., died two weeks later at home. Death was attributed to sudden infant death syndrome. Patient B lives apart from her children, who now reside with their grandmother. This patient, despite drug counseling, smoked one pack of cigarettes daily, frequently consumed alcohol and smoked crack cocaine daily during this pregnancy. Her urine tested positive for cocaine on admission. One month before delivery, she was treated for gonorrhea and syphilis. Screens for hepatitis and A.I.D.S. were negative. Four hours after arrival she delivered a 4 lbs 15oz. growth retarded infant, but with no significant debilities observed. Mother and infant were discharged with public health home evaluation planned and referral made to Broward Alcohol and Rehabilitation Center. The cycle continues.

From my view point, sucessful prenatal management in the presence of maternal cocaine addiction is an unobtainable goal. The solution must embody prevention and salvage. Prevention can only be achieved by cutting the flow of drugs and improving those socioeconomic conditions which allow cocaine use to flourish and appear acceptable. Salvage of a large drug debilitated population can be facilitated by increasing support to drug rehabilitation programs and infant treatment-monitoring services, thereby making them accessible to persons of meager financial means. If this is not done, the future of our country is in grave jeopardy

Miles Wilson, M.D., Director
Sunlife OB/GYN Services, Inc.

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COMMITTEE PHONE 202-226-3040

November 18, 1987

Honorable Gregory L. Coler, Secretary
Florida Department of Health and
Rehabilitative Services
1323 Winewood Boulevard
Tallahasse, Florida 32301

Dear Mr. Secretary:

Recently the Select Committee on Narcotics Abuse and Control held a hearing in Ft. Lauderdale, Florida, on the problem of babies born to mothers addicted to cocaine. Representatives of the Florida Department of Health and Rehabilitative Services for District 10 testified at the hearing about the implementation in Broward County of HRS policies to address this problem.

One of the issues that arose at the hearing was the lack of adequate treatment services for substance abusing pregnant women. The Committee attempted to determine how much HRS District 10--Broward County--had received as a result of the enactment last year of the Anti-Drug Abuse Act of 1986 which provided $163 million in new Federal funds for emergency substance abuse treatment block grants to the States. There was some confusion on this point, but it is our understanding that HRS in Tallahassee initially told the District 10 office it would receive $750,000 or $650,000 under the Anti-Drug Abuse Act. Later, however, the amount was reduced to $450,000. It also was not clear whether the final allocation represented just Federal funds under the Anti-Drug Abuse Act or also included some State funds.

The additional funding for drug abuse treatment in the Anti-Drug Abuse Act was a direct outgrowth of legislation proposed by this Committee. For this reason, we have a special interest in knowing how this program is being administered. We would appreciate your assistance in clarifying a number of points about the situation in Broward County.

We would like to know what amount was allocated initially for District 10 from Florida's emergency substance abuse treatment block grant under the Anti-Drug Abuse Act. We also would like to know how Broward County's initial allocation was determined, why it was reduced later by $200,000 or $300,000, and who made these decisions, (i.e., HRS in Tallahassee, the State Legislature or some other State agency or official). Finally,

we would like to know the level of State funding, exclusive of Federal funds, made available by HRS for substance abuse treatment services in Broward County for each of fiscal years 1986, 1987, and 1988.

Thank you for your cooperation in this matter. We look forward to your reply and plan to include it in the printed record of our hearing in Ft. Lauderdale.

Sincerely,

BENJAMIN A. GILMAN,
Ranking Minority Member

CHARLES B. RANGEL,
Chairaman

E. CLAY SHAW, JR.,
Member of Congress

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

January 6, 1988

Honorable Charles B. Rangel, M.C.
Honorable Benjamin A. Gilman, M.C.
Honorable E. Clay Shaw, Jr., M.C.
U.S. House of Representatives
Select Committee on Narcotics Abuse
and Control
Room H2-234, House Office Building Annex #2
Washington, DC 20515-6425

Dear Congressmen:

In response to your November 18 letter regarding the Anti-Drug Abuse Act funds received by the State of Florida, the following information is provided:

1. The State of Florida received $7,314,000 in anti-drug abuse funds for use over a two-year period from October 1986 to September 1988. The Florida Legislature appropriated $5,832,788 of the funds for use during the period from July 1987 to June 1988. The balance of $1,481,212 will be appropriated by the Florida Legislature for use during the period July 1988 to September 1988. These funds were to be utilized for detox, residential, assessment and evaluation, and outpatient services at the HRS districts' discretion to expand treatment services for the "crack"/cocaine problem in Florida.

2. The initial allocation proposed in March 1987 for District 10 was $693,608 for use over a 15-month period (April 1987-June 1988). The initial proposed allocation methodology was jointly prepared, reviewed and approved by the eleven HRS district alcohol, drug abuse and mental health program offices. The methodology used population and services needs data from all eleven districts. The governor's office, however, after consultation with the Florida House and Senate, did not approve the department's initial proposed allocation of the federal funds, and the funds were subsequently allocated by the Florida Legislature while in session. Following the legislative session, allocations to all districts were revised. District 10 received $468,647 for the period July 1987 to June 1988 and will receive an additional $93,729 for the period July 1988, to September 1988 for a total of $562,396 Anti-Drug Abuse Act funds.

3. The following is a recap of state funds allocated for substance abuse treatment services in Broward County for the past three fiscal years:

1985-86 $2,167,251
1986-87 $2,431,057
1987-88 $2,588,413

The State of Florida greatly appreciates the Anti-Drug Abuse Act funding and has made every attempt to spend the funds for the purpose intended. If further information is needed, please let me know.

Sincerely,

Gregory L. Coler

Gregory L. Coler